

HEALTH CARE FRAUD

Y 4. J 89/2: S. HRG. 103-1041

Health Care Fraud, S.Hrg. 103-1041,...

HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

EXAMINING FEDERAL, STATE, AND LOCAL EFFORTS TO COMBAT FRAUD
AND ABUSE IN THE HEALTH CARE INDUSTRY AND RELATED PROVI-
SIONS OF THE PROPOSED HEALTH SECURITY ACT

MAY 25, 1994

Serial No. J-103-57

Printed for the use of the Committee on the Judiciary



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HEALTH CARE FRAUD

WEDNESDAY, MAY 25, 1994

U.S. SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The committee met, pursuant to notice, at 2:21 p.m. in room SD-226, Dirksen Senate Office Building, Hon. Joseph R. Biden, Jr., (chairman of the committee), presiding.

Also present: Senators Grassley and Cohen.

OPENING STATEMENT OF HON. JOSEPH R. BIDEN, JR., A U.S. SENATOR FROM THE STATE OF DELAWARE

The CHAIRMAN. The hearing will come to order.

The President and this Congress have made comprehensive reform in the health care system a key priority this year. The Judiciary Committee convenes this hearing today as part of a coordinated effort by the Senate committees to conduct a full review of the President's health care reform proposals.

Twenty-five years ago, health care spending totaled just 5 percent of the Nation's economy. Since then, its share has almost tripled, to 14 percent, over \$1 trillion, in 1994. The President's health care reform legislation seeks to bring those costs under control, even while ensuring better care for all Americans.

A key part of the President's plan to control costs is to reduce the amount of fraud in the system. And make no mistake about it, there is plenty of fraud. While it is impossible to come up with a precise dollar amount, most experts—and we have held hearings on this before—estimate that fraud accounts for about 10 percent of health care expenditures.

The American public pays for this fraud. Fraud against private insurers is passed along to consumers in the form of higher prices for health insurance. Fraud against Medicare or other government programs is, of course, paid for by the taxpayers directly. Either way, the American public pays the bill.

Let's put this in perspective. In 1994, there will be an estimated \$100 billion worth of fraud in the provision of health care services. That means that a family of four will spend approximately \$1,600 this year just to line the pockets of a few.

The types of fraud are virtually limitless—pharmacists who charge for brand name drugs but supply generic brands instead; doctors who charge for tests they never perform; medical equipment suppliers who pay kickbacks to doctors who recommend their products; home health nurses who falsify patients' records to justify unnecessary visits; con artists who call people on the phone to get

them to come into a clinic for a battery of tests they don't need; hospitals and home health companies who disguise purely personal or private expenses and then submit them to Medicare for reimbursement; doctors or laboratories who send bills for the same services to two different Medicare offices or to private insurers and Medicare; and companies that drive healthy, walking people to a doctor's office and then bill them for the expense of an emergency ambulance.

But the one thing all forms of fraud have in common is that they put money in one person's pocket at the expense of the American public. In fact, the health care industry is uniquely vulnerable to some forms of fraud because the person who receives the services is not the one who pays for it. Those who provide health care services normally send the bill directly to an insurer or to the Government, and it is likely to be paid without question.

The payer doesn't routinely check to make sure that the service or product was provided or even needed. It doesn't usually check to make sure the price hasn't been inflated in some way. It simply pays. Most providers are honest and don't abuse this trust, but some succumb to temptation and greed, largely because they know they are unlikely to get caught.

Improving government efforts at catching those who engage in fraud, the focus of a bill I authored that passed the Senate in 1992, must be a part of any effective health care reform proposal, and I am not suggesting mine is the only such bill.

The President's Health Security Act addresses this problem by expanding Federal investigative authority and by creating a special account into which criminal and civil recoveries from health care fraud investigations will be deposited and then used to fund further fraud investigations.

Putting resources into fraud enforcement pays off. Insurance companies report returns of \$5 dollars or more for every dollar spent on fraud detection and prevention, and a recent GAO report found that the Government saved far more than it spent by increasing Medicare fraud protection efforts.

Everyone who pays health care bills—the Federal Government, State governments, private insurers, and in every case the public—has a big stake in this fraud problem. Both the Government and private insurers must continue and improve active fraud detection and prevention. The President's Health Security Act includes a thoughtful, in my view, and comprehensive fraud program. I look forward to discussing this program with our witnesses today and I welcome all of them to this committee.

I will note that there are others on this committee who have been leaders in this area, like Senator Cohen of Maine, who have slightly different approaches. The point is I think there is a pretty universal view shared by Democrats and Republicans that this is a problem and it must be addressed.

We have a statement from Senator Kohl and the American Health Care Association which we will include in the record.

[The prepared statements of Senator Kohl and the American Health Care Association follows:]

PREPARED STATEMENT OF SENATOR HERBERT KOHL

Mr. Chairman, I'd like to first thank you for holding this important hearing and for championing this crucial issue for so long. Before the political winds brought the subject of health care reform into the Senate, you were sounding the alarm that unprincipled providers were pilfering our national health pocketbook.

Everyone, of course—patients, providers, policymakers—is against health care fraud. In this sense, it is an easy issue, because we all start on the same page. In a health care economy that borders on one trillion dollars annually, experts estimate that fraud and abuse is costing us tens of billions of dollars every year.

These are dollars taken from private insurance carriers, state and federal governments and, ultimately, the pockets of individual Americans. These are dollars that could be used to cover millions of Americans who now go without insurance. I think we all agree that for a health care reform package to come out of Congress without addressing this issue would be unacceptable.

The difficult question comes when we get down to specifics: what can we do to better prevent and deter fraud in the delivery of health care?

Mr. Chairman, the legislation you have introduced in the past, which would toughen criminal penalties, is an important start. But criminal fraud is only a part of the problem.

My concern is that our health care system is being ripped-off daily by those who see health care as a giant game: a game in which unprincipled providers are rewarded for pushing the edge of the envelope, and exploiting what they rationalize as loopholes. This game is pursued much like some people try to fool the IRS: it is not necessarily criminal but, as our witnesses will tell us, it is nevertheless unlawful and we *should* prosecute it through civil enforcement.

In short, I think our civil health care fraud laws need to pack a tougher punch if we are to deter unlawful conduct that falls just shy of criminal behavior. I have introduced legislation that would do just that, in addition to toughening existing civil penalties. This legislation would more than double existing civil penalties, expand the scope of those penalties to cover additional fraudulent conduct, and allow for the imposition of community service obligations on providers who have violated the law.

Equally important, we need to look at expanding our existing civil sanctions to also cover fraud against private payers, as my legislation would also do. The federal government currently accounts for approximately 30 percent of UPS. health care spending, and the core elements of our existing health care fraud laws only protect against conduct that defrauds the government. But what about the other 70 percent of our health care spending?

It is high time that we send the message that the federal government will not tolerate fraud and abuse in any health care transaction, whether the target of the fraud is a private payer or a public payer. No matter who appears to be the victim of fraud and abuse, all Americans end up paying the price when costs and premiums skyrocket as a result. That is why I hope the Administration will support Chairman Biden's measure and why hope it will support mine as well.

Let me just conclude by commending the Departments of Justice and Health and Human Services for the outstanding work they have already done in this area. In recent years, they have rolled up their sleeves and pursued health care fraud with skill and tenacity. Last year alone, the federal government collected more than \$177 million in health care fraud penalties. I am confident that if we work together, and give our fraud investigators and prosecutors the laws and resources they need, we can produce even better results—and save considerably more money—in the years to come.

 PREPARED STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION

Senator Biden, Senator Hatch and members of the Committee, the American Health Care Association (AHCA) appreciates the opportunity to provide you with our Association's position on ways to combat fraud and abuse in the health care delivery system. AHCA is a federation of 51 affiliated associations representing 11,000 non-profit and for-profit nursing facilities, residential care, and subacute providers nationwide.

AHCA fully supports efforts to combat fraud and abuse in health care. We have worked with Congress and the Administration on ensuring that quality care is provided to nursing home residents and that compensation be fair and equitable to both the government and to providers. We are continuing efforts to ensure that providers comply with federal law by working with the Health Care Financing Administration to advise our members on what constitutes inappropriate billing practices.

FRAUD AND ABUSE PROVISIONS

We are pleased that the Committee is examining this issue and the proposed changes in fraud and abuse law. Provisions to modify Federal health care fraud and abuse statutes are contained in a number of health care reform proposals, including the President's Health Security Act (S. 1757) and in the Senate passed Omnibus Anticrime bill (H.R. 3355).

The Health Security Act contains the following provisions.

It creates a new standard for health care fraud as a new federal crime. Such action will be a felony with fines up to \$250,000 and ten years of imprisonment, or life imprisonment if the violation results in serious bodily injury. This would apply to both federally and privately financed health care activities.

If a health care offense poses a serious threat to the health of any person or has a significant detrimental impact on the health care delivery system there can be imposed criminal forfeiture of property that is used, supported, or added value to the commission of the offense.

Any individual, engaged in a pattern of health care fraud, Food and Drug Administration violations, or anti-kickback violations could be civilly or criminally prosecuted under the Racketeer Influenced and Corrupt Organizations (RICO) statute.

Any individual with certain controlling interest in an entity that has been sanctioned through criminal prosecution, civil money penalties or program exclusion may be excluded from health care programs even if the individual had absolutely no responsibility for the conduct that led to the sanction.

Federal, State and local law enforcement programs will coordinate their efforts to control fraud and abuse by developing joint enforcement programs and sharing information and resources.

Civil monetary penalties and penalties for false claims would be increased. Such penalties will be applied to providers who incorrectly code services or provide medically unnecessary services. This would apply to claims submitted to both Federal and private insurance plans.

Persons, other than beneficiaries who suffer harm or monetary loss as a result of any activity of an individual or entity which would subject that individual to civil monetary penalty, may bring an action against that provider in Federal court.

PROBLEMS AND IMPROVEMENTS TO PROVISIONS

AHCA believes that there are two problems with the aforementioned fraud and abuse proposal. First, it relies solely on enforcement and there is no effort to enhance prevention and compliance. Second, it reaches far beyond those who purposefully act with criminal intent.

Improving compliance

While enforcement is important, many problems such as miscoding or improper billing of services can be remedied through education and guidance by the Federal government. Medicare and Medicaid laws and regulations are extremely complex and it is difficult for providers to determine if they are in compliance. The breadth and lack of clarity of the current fraud and abuse laws has created confusion and uncertainty for providers working to develop innovative, lawful arrangements for the delivery of long term care services. Without clarification, this confusion and uncertainty is likely to increase with the dramatic expansion of the fraud and abuse laws contemplated by numerous legislative proposals.

Currently the U.S. Department of Health and Human Services, Office of the Inspector General is prohibited from providing advisory opinions to health care providers seeking to enter into innovative ways to deliver long term care services. Congressman Hoagland (D-NE) has introduced legislation (H.R. 4028) which authorizes the Secretary of Health and Human Services to issue such opinions. This will greatly aid providers in ensuring that they stay in compliance with Federal law when delivering services in a rapidly changing health care delivery system.

Another step that Congress can take is to allow long term care providers to petition the Office of the Inspector General to issue "Fraud Alerts." In the past, the Office of the Inspector General has issued such "Alerts" when it wished to make the industry aware that it considered certain conduct unlawful (or potentially unlawful). Permitting health care providers to request Fraud Alerts regarding contemplated transactions would provide increased clarity concerning the Office of Inspector General's interpretation of the law and would thereby promote compliance.

Ensuring honest providers are not harmed

While AHCA fully supports the intent of the provisions, we are concerned that they would extend beyond those who willfully defraud the government to honest

providers who innocently commit an error or disagree with an insurance company's perception of a patient regimen of treatment. Some specific examples are as follows.

Section 4043 would provide civil monetary penalties for miscoding of procedure or diagnosis codes, providing items or services in excess of medical need, or providing services not medically necessary. The practice of medicine is as much an art as a science. A practitioner must deal with many uncertainties, and may try a variety of approaches to diagnose a condition and treat it. In many cases medical necessity is a judgment call and judgment can be influenced whether you are a provider delivering services or a claims reviewer seeking to keep down costs. This provision should be limited to cases where willful intent to commit fraud is demonstrated.

Section 4044 provides for the permissive exclusion of individuals simply because they own shares in a sanctioned entity even if the individual had absolutely no responsibility for the conduct that led to the sanction. The individuals to whom the exclusion authority would apply include anyone with an investment interest of 5 percent or more, or anyone with management responsibilities, including members of the Board of Directors. As a result, an individual, simply by his or her relationship or status with a company, can be excluded from health care programs, even if the individual had no knowledge of, or responsibility for, the events that lead to the sanction on the company. In fact, the proposal does not even require that the individual was affiliated with the company at the time the conduct occurred on which the sanction is based. This provision will make it virtually impossible to obtain medical professionals to sit on Boards of Directors of long term care facilities. Clearly, responsibility must be brought back into the determination process.

CONCLUSION

AHCA supports the effort to ensure compliance with Federal Health care laws. While the effort to ensure greater enforcement is commendable, we must ensure that long term care providers who seek to operate within the law have the proper guidance. In addition, we must ensure that criminal law does not extend to those who have no criminal intent. The provisions must be tightened up to limit their scope to those who willfully violate the law. To that end we will be happy to work with you and your Committee.

Now, I would ask either of my colleagues, since I have delayed them particularly, if they have any brief opening statements they wish to make.

Senator GRASSLEY. I do not have an opening statement.

The CHAIRMAN. Senator Cohen?

STATEMENT OF HON. WILLIAM S. COHEN, A U.S. SENATOR FROM THE STATE OF MAINE

Senator COHEN. Mr. Chairman, I want to thank you for holding the hearing on health care fraud. As you indicated, it is a subject matter that I have been interested in for a long time.

You also pointed out that the GAO has estimated that we lose approximately \$100 billion a year through fraud in the health care system. To put it all in perspective, we had a great deal of anguish over the S&L bailout legislation that we had to pass and appropriations we had to make. It totaled, according to the FBI, about \$80 billion. Here, we are losing \$100 billion every single year, which works out to about \$275 million a day.

While we have passed some reforms aimed at preventing another S&L crisis from occurring, we haven't done very much to deal with health care fraud to date. I think it is going to be clear from the testimony that the laws we have on the books are insufficient, that the Justice Department has to search and look for some kind of nexus in either mail or wire fraud statutes in order to bring action against those who are engaging in this fraud, and that we are seeing a decrease in Health and Human Services investigators at the very time that we need more and not less.

We are going to be releasing a minority staff report on the Aging Committee soon. I want to give you just a couple of examples of the kinds of schemes that are going on on a daily basis.

We have one example of a scheme in which cardiac pacemakers were altered, involving inducements and endangering lives. The owner of a distribution company altered the expiration dates on the pacemakers, resulting in, "expired" pacemakers being implanted in patients. According to the FBI, cardiologists and surgeons were given inducements, such as entertainment tickets, vacations, office medical equipment, cash, and even the services of prostitutes, in exchange for using the heart devices.

Physician-owners of a psychiatric clinic stole more than \$1.3 million from Medicaid by billing for over 50,000 phantom psychotherapy sessions that were never provided. A radiologist allegedly stole \$1 million from Medicare by billing for thousands of ultrasound tests he never reviewed. A speech therapist bilked Medicare for payment of services he never provided to nursing home residents and he billed for services dated several days after the residents had actually died.

These are just examples of the kinds of abuse that are taking place on a daily basis, and the very size and the intricacy and the splintering of the current health care system makes this possible.

We also have a situation where the intermediaries are trying to make payments as quickly as possible, so the pressure is on them to pay the bills so the hospitals and doctors can get reimbursed. So, again, not enough effort is made in order to question suspicious billings and other types of claims.

I suspect, Mr. Chairman, that as we move toward some form or variation of managed care in our health care reform debate that is taking place, it is going to open the door to new possibilities for even greater fraud that we have to be wary of.

Now, the Senate, when it passed the crime bill, thanks to you, also accepted a criminal provision dealing with health care fraud, and I sincerely hope that the chairman will work to continue that. There is, I think, some pressure on to say, wait a minute, we don't need to pass any kind of health care fraud legislation; let's wait until we get the health care bill itself.

I would respectfully dissent from that view. I don't think we can afford to wait to find out whether the President's bill is going to pass. I hope it passes, or some form of his bill, or the Chafee bill or whatever the name is going to be. But that is no guarantee, and we may not get to it until September or October, if we get to it. In the meantime, we are losing \$275 million a day. So I don't think anyone can make a case for delaying health care fraud legislation from going forward now and not waiting any longer.

I have a number of proposals, Mr. Chairman. I won't take the time now, since the witnesses are waiting, to outline what I believe to be an appropriate and comprehensive approach to legislating in the field of health care fraud, but I don't think we should delay by one day any effort on our part to pass this now and not wait for the President's program to be considered and adopted. This is something we can do today and we ought to do today.

Thank you.

The CHAIRMAN. It does not make my party or my President happy, but I agree with you.

Our first panel of witnesses is made of two distinguished persons. The first is Gerald Stern. Mr. Stern is a special counsel for health care fraud at the Department of Justice and is in charge of the civil and criminal enforcement effort. Our second witness is Mr. Michael Mangano, who is the Principal Deputy Inspector General at the Department of Health and Human Services, which is charged with investigating fraud in Medicare, Medicaid, and in Social Security, and that is one heck of a job.

I truly appreciate both of you being here. I apologize for the late start. Mr. Stern, why don't we begin with you?

PANEL CONSISTING OF GERALD M. STERN, SPECIAL COUNSEL, HEALTH CARE FRAUD, AND SPECIAL COUNSEL, FINANCIAL INSTITUTION FRAUD, U.S. DEPARTMENT OF JUSTICE; AND MICHAEL MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF GERALD M. STERN

Mr. STERN. Thank you, Chairman Biden and Senators Grassley and Cohen, for this opportunity to discuss the pressing problem of health care fraud.

Ensuring that all Americans have access to quality health care at a reasonable cost is a fundamental principle of the administration's health reform efforts. This goal, however, cannot be reached if health care fraud goes unaddressed. Fraud can undermine both the cost and the quality of health care. Fortunately, the Health Security Act not only decreases opportunities for fraud, it also increases the likelihood that the fraud which may occur will be met with the strong arm of law enforcement.

Before turning to the future, I would like to describe briefly the present health care fraud enforcement program which sets the foundation for the future. The Department of Justice is responding to the health care fraud crisis to the fullest extent possible, given the existing resources and remedies.

The number of cases investigated and prosecuted has risen dramatically over the last few years and will continue to grow. Indeed, the FBI statistics taken at a specific point in time at the end of March 1992 showed they were investigating 364 cases. The same bird's eye view in March 1994 showed they were investigating 1,230 cases.

The Attorney General has made health care fraud her number 2 new initiative, and she has asked me to coordinate the Department of Justice's health care fraud efforts. In Washington and in U.S. attorneys' offices across the country, we are working with the Federal Bureau of Investigation, with the Inspector General of Health and Human Services, with the other inspectors general who handle health care fraud in the other agencies, and with numerous Federal investigative agencies. Our other important partners in health care fraud enforcement also are at the State level with the State Medicaid fraud control units and with the State attorneys general offices.

Our experience to date demonstrates that health care fraud enforcement is most effective when we pursue a multi-prong attack. First, the prosecutors bring criminal charges against the responsible companies and persons. Second, the civil attorneys collect damages and penalties. The third arm of enforcement is HHS and the other agencies which impose administrative sanctions, such as exclusion or suspensions.

To better coordinate all of this health care fraud enforcement, last November we established an executive level health care fraud policy group, which I chair and which has been meeting monthly at the Department of Justice. The members include the Inspector General of HHS, senior members of the Criminal and Civil Divisions of the Department of Justice, and the FBI. This group has been addressing emerging fraudulent schemes throughout the country, national priorities, the sharing of data and investigative techniques, and more efficient ways for us to work together and coordinate our efforts.

Also important are various national and local health care fraud working groups which we have both at the national level and in almost every one of our major cities today. They bring together the Federal and the State prosecutors and the investigators, who often then meet with the providers. They meet with private insurance companies and citizens groups.

In fact, Senator Grassley, the Attorney General was in Iowa, in Des Moines, meeting with the health care fraud working group which we started up there, and also spoke with the folks over in Cedar Rapids where we have a lot of the private insurance carriers both in Des Moines and Cedar Rapids. So, that is a very good example of our effort which has been reproduced in other States to create these health care fraud working groups across the board.

Notwithstanding our vigilant efforts, perpetrators of health care fraud will continue to prey upon the health care system. They simply will reshape their schemes to fit the particular reimbursement system, whether it be fee-for-service, managed care, or managed competition.

Fraud affecting fee-for-service plans includes billing for services not rendered or not necessary, double billing, and illegal remuneration such as kickbacks for patient referrals. Fraud in managed care reflects the different reimbursement scheme there. There, you have a fixed fee for an enrollee which controls the use of services through a network of providers. In that situation, unscrupulous practices may include impeding access to care, rather than giving too much care, or encouraging the exclusion of costly consumers, or just failing to provide medically necessary services altogether.

Managed competition, which is the system envisioned by the Health Security Act, will actually provide for both fee-for-service and managed care plans. So we anticipate the same kind of health care fraud schemes we now see, plus we anticipate new schemes, such as improperly trying to influence the selection and terms of plans or false or misleading submissions in the bid process. The President's bill attempts to address these problems, as well as others.

Senator Biden, because the red light is on, I could stop at this point and wait and deal with the questions. I have outlined most

of what I am saying orally in the written statement I have presented.

The CHAIRMAN. OK, thank you.

[The prepared statement of Mr. Stern follows:]

PREPARED STATEMENT OF GERALD M. STERN

Chairman Biden and Members of the Committee: Thank you very much for this opportunity to discuss the pressing problem of health care fraud and its future under health care reform.

Ensuring that all Americans have access to quality health care at a reasonable cost for them and for the nation is a fundamental principle of the Administration's health reform efforts. This goal, however, cannot be reached if health care fraud goes unaddressed; fraud can undermine both the cost and quality of health care. Fortunately, the Health Security Act not only decreases opportunities for fraud, but also increases the likelihood that whatever fraud occurs will be met with the strong arm of law enforcement. Before turning to the nature of health care fraud in the future, it is necessary to describe the Department of Justice's health care fraud enforcement program, which establishes a foundation for all future enforcement efforts.

HEALTH CARE FRAUD: THE CRISIS

While no one has an exact figure, health care fraud presently may count for as much as 10 percent of all health care expenditures. Health care expenditures now total approximately one trillion dollars each year, so that as much as \$100 billion may be lost in fraud annually.

Everyone pays the price for health care fraud: beneficiaries of government health insurance such as Medicare pay more for medical services and equipment; consumers of private insurance pay higher premiums; and taxpayers pay more to cover health care expenditures.

While most health care providers are honest and care first and foremost about their patients' welfare, fraud is perpetrated by every kind of provider: individual physicians, as well as multistate publicly traded companies; medical equipment dealers, ambulance companies, and laboratories as well as the hospitals and nursing homes they service.

The horror stories are rampant. For example, recent Department of Justice ("DOJ") cases have involved the following frauds:

- Two patients died and 22 others required emergency coronary bypass surgery when a Fortune 500 company distributed unapproved heart catheters to hospitals and physicians. It preferred immediate profits to waiting for FDA clearance. The company, C.R. Bard, Inc., pleaded guilty in Boston to conspiracy, mail fraud and 363 violations of the Food, Drug and Cosmetic Act. It agreed to pay \$30.5 million in fines and criminal forfeitures and an additional \$30.5 million to resolve the government's civil claims. Individual corporate officials face trial in the near future.
- A mobile diagnostic testing service and numerous medical and diagnostic testing clinics billed more than \$1 billion in fraudulent claims to private insurance companies and more than \$50 million in payments for unnecessary tests. Prosecutors believe that CHAMPUS received more than \$29 million in fraudulent claims and paid out more than \$1 million as a result of the scheme. The principals in this scam have pleaded guilty to mail fraud, conspiracy and money laundering.
- An attorney was convicted in Philadelphia in March 1994 of 107 counts of mail fraud and 17 counts of money laundering in connection with his operation of three unlicensed insurance companies, which falsely claimed that the policies were funded by Blue Cross. His companies took in \$34 million in health insurance premiums and left victims with \$5.8 million in unpaid claims. He faces between 97 and 121 months in prison and will be sentenced in the near future.
- Workers of small employers who sought to buy affordable health insurance from self-funded group health plans known as multiple employer welfare arrangements ("MEWAs") found themselves with unpaid medical bills because fraudulent MEWAs purchased reinsurance from offshore insurance companies with few, if any, assets.

DEPARTMENT OF JUSTICE HEALTH CARE FRAUD ENFORCEMENT PROGRAM

The Department of Justice is responding to the health care fraud crisis to the full extent possible given existing resources and legal remedies. In 1992, the Federal Bureau of Investigation ("FBI") launched a health care fraud initiative which included new training, new agents and task forces dedicated to health care fraud. The FBI's caseload has increased dramatically. As of October 1, 1991, the FBI had 365 pending health care fraud investigations. By October 1993, this number had grown to 1,051 pending investigations. It now exceeds 1,300.

Health care fraud matters and cases handled by United States Attorneys and other Department of Justice attorneys similarly have risen dramatically over the last few years. In fiscal year 1992, there were 343 criminal health care fraud matters pending; as of December 31, 1993, this number had more than doubled to 711. Civil health care fraud matters also more than doubled in the same time period. Recent victories have included:

- In 1992, National Health Laboratories, Inc. ("NHL") and its president and CEO pleaded guilty in San Diego to submitting false claims to the United States. The corporation paid a \$1 million criminal fine, the President paid a \$500,000 criminal fine and served three months in prison. The corporation also paid \$100 million in a settlement of civil claims involving Medicare and CHAMPUS, and \$10.4 million to 33 state Medicaid Fraud Control Units.
- In 1994, McKesson Corporation paid \$765,000 to settle claims it overcharged the Oregon Medicaid program for the cost of drugs dispensed to State Medicaid recipients. The United States charged that McKesson had submitted several hundred thousand claims for payment to Medicaid for prescription drugs in which they falsely represented that the brand name drug—which was more expensive than the generic drug—was medically necessary.
- Several hospitals submitted duplicate and/or misleading bills which charged separately for services already included as part of a bill for an entire hospital treatment. In Alabama, the United States Attorney's Offices recently recovered over \$580,000 from several hospitals who double billed Medicare for inpatient and outpatient services.

Although the Department of Justice is proud of its record, we recognize that these cases are only the "tip of the iceberg."

FUTURE SUCCESS REQUIRES INTERAGENCY COOPERATION

The Department of Justice has long worked with the Department of Health and Human Services Office of Inspector General ("HHS OIG") to investigate and prosecute health care fraud in Medicare and with the HHS OIG and the state-based Medicaid Fraud Control Units ("MFCU's"). We anticipate a continued collaborative relationship with the MFCUs, especially as we build on their experiences with fraud in managed care settings.

Other federal investigatory agencies also committed to combating health care fraud include, but are not limited to, the Defense Criminal Investigative Service, the United States Postal Service, the Railroad Retirement Board, the Department of Veterans Affairs Inspector General, and the Pension and Welfare Benefits Administration and Inspector General of the Department of Labor.

The Department of Justice is most effective in combating health care fraud when it pursues criminal, civil, and/or administrative proceedings, where appropriate. Increasingly, our cases comprise parallel proceedings where the responsible companies and/or officials plead guilty or are convicted criminally and at the same time, civil damages and penalties are collected. The Department of Justice has several civil fraud initiatives, targeting frauds not prosecuted criminally. For example, United States Attorneys' Offices in Scranton, Pennsylvania, in Alabama and elsewhere have targeted hospitals with credit balances and with duplicate billing records; the United States Attorney's Office in Philadelphia is suing physicians who bill patients more than permitted under Medicare or a Federal Employees Health Plan. Thanks to these efforts, health care fraud that may not constitute criminal activity nevertheless is prosecuted; the government recovers its damages, civil penalties are paid and the victims of health care fraud receive restitution. This is important whether the victims of health care fraud are individual patients or health care insurance systems, including Medicare and Medicaid.

The Department of Justice also fully cooperates with the efforts of the HHS OIG to implement administrative remedies, the third arm of enforcement. Exclusions, suspensions or administrative civil penalties are often the appropriate response to health care fraud and abuse. Prosecutors, investigators, and health system administrators must work together not only to punish perpetrators of health care fraud and

recover monetary losses, but also to stop perpetrators from profiting from ongoing fraudulent schemes and to prevent those who committed fraud in the past from repeating the fraud in the future.

To implement this multipronged strategy with respect to the Medicare program, the Department of Justice works closely with the HHS Inspector General and with the Health Care Financing Administration ("HCFA"). For the first time, we have institutionalized regular meetings between DOJ, HHS OIG, HCFA and the Medicare contractors at the national, regional and local levels to discuss trends in fraudulent practices and devise possible solutions to stop ongoing fraud. Medicare contractors' recently formed Fraud and Abuse Units and Health Care Fraud Coordinators also help detect and prevent fraud, and assist law enforcement in investigating and prosecuting these cases. DOJ, HHS OIG and HCFA also are working together to ensure that, as electronic claims processing becomes universal, critical evidence of health care fraud is not eliminated. We are exploring pilot advanced electronic fraud detection programs. As fraudulent schemes become more sophisticated so must our methods of detection.

Several vehicles now facilitate communication and coordination among health care fraud enforcement authorities. Last November, we established an Executive Level Health Care Fraud Policy Group, which I chair, to develop national health care fraud enforcement policy. Members include the Assistant Attorneys General for the Criminal Division and Civil Division, the Department of Health and Human Services Inspector General, and a senior FBI official. The United States Attorneys are represented by the Co-Chair of the Attorney General's Advisory Committee, Health Care Fraud Subcommittee. This forum permits policy development and coordination at the highest levels of the Department of Justice and the Department of Health and Human Services. It already has tackled issues such as identification of emerging fraudulent schemes, development of national priorities, sharing of data and investigative techniques, and development of an accelerated recovery and voluntary disclosure program.

In addition to the Executive Level Health Care Fraud Policy Group, health care fraud working groups exist at the national, regional, and local levels, many of which include federal and state prosecutors and investigators from FBI, HHS OIG, and other federal agencies as well as state Medicaid Fraud Control Units. Many of these working groups also work with private insurance companies to share information on fraudulent schemes and investigative techniques.

FUTURE OF HEALTH CARE FRAUD

The Department of Justice's health care fraud enforcement program establishes a strong foundation for our future enforcement efforts. Unfortunately, perpetrators of health care fraud will attempt to prey on any health care system Congress adopts; they simply will reshape their schemes to fit the particular form of reimbursement: fee-for-service, managed care, or managed competition.

Fee-for-services health plans are common under the present health care system. Fraud affecting these plans can include billing for services not rendered; billing for services not necessary; double billing; manipulated billing to maximize reimbursements by upcoding or unbundling services; and illegal remuneration such as offering or accepting kickbacks for patient referrals. Many Department of Justice cases presently involve these types of schemes.

Fraud under managed care plans reflects the different reimbursement scheme. A health maintenance organization ("HMO") is paid a capitated or fixed fee for an enrollee and is responsible for controlling use of services through a limited network of providers. Whereas fee-for-service plans see overutilization, managed care plans see underutilization. Here unscrupulous practices can include impeding access to care or encouraging disenrollment of costly consumers; failing to provide medically necessary services; or providing financial incentives for enrolling consumers unlikely to use lots of medical services. States with managed care plans such as Arizona, Michigan, and California have experienced these kinds of cases. Unfortunately, so has the federal system. One recent case litigated by the United States Attorney's Office for the District of Columbia illustrates one type of scam:

- Group Health Association, Inc. ("GHA"), a Health Maintenance Organization, agreed to pay \$12,629,123 to resolve claims by the United States that GHA overcharged federal agencies and employees for health care benefits from 1990 through 1993, based on misleading disclosures of rates paid to other large groups of employees.

Managed competition, the system envisioned by the Health Security Act, would include fee-for-service and managed care plans. Therefore, we should anticipate at-

tempts to continue health care fraud schemes we now see in fee-for-service and managed care plans. In addition, we may see attempts to improperly influence officials regarding the selection and terms of plans; false submissions in the bid process; false representations to induce enrollments; and misrepresentations of consumers' health to justify higher payments under risk adjustment formulas.

These problems are far from unique to the Administration proposal; yet, only the Health Security Act contains the comprehensive health care fraud control program necessary to combat them. The Administration's proposal eliminates many opportunities for fraud by simplifying health care reimbursement. To address the fraud that unfortunately will still occur, the Act establishes an All-Payer Anti-Fraud Control Program and provides the criminal, civil, and administrative tools necessary for stronger and more meaningful health care fraud enforcement. Finally, it establishes a reliable source of supplemental resources for health care fraud enforcement paid for by the perpetrators of the fraud.

First, the present multiplicity of health care systems facilitates health care fraud and abuse while fragmenting our efforts to combat it. Americans receive health care from a plethora of private health insurance companies and public programs. There are over one thousand different payers. Public programs alone include Medicare, Medicaid, the Civilian Health and Medical Program of the Uniformed Services, known as CHAMPUS, and Federal Employee Health Programs. Each program has its own rules for the provision of services and for the reimbursement of costs. There are hundreds of different claim forms, multiple identification numbers, coding systems and billing procedures. Information sharing among payers frequently is poor.

The fragmentation of the health care system is mirrored by the multiplicity of law enforcement agencies dedicated to investigating fraud in a specific health care system. For example, the HHS OIG primarily addresses Medicare and Medicaid fraud (the latter through the Medicaid Fraud Control Units), the Defense Criminal Investigative Service focuses on CHAMPUS fraud, and the Department of Labor Inspector General and the Pension and Welfare Benefits Administration investigate fraud in employee health benefit programs. In the past, many of these agencies set their priorities focusing exclusively on their specific program concerns, available data and resources.

Perpetrators of health care fraud currently exploit the multiplicity of health care systems and their respective forms, codes and procedures. They rarely infiltrate just one health care system. Due to the program-specific focus of law enforcement, health care fraud investigations may risk being piecemeal and inefficient and, as a result, our ability to detect emerging trends and the full scope of a fraud may be compromised.

The Health Security Act eliminates many of the opportunities for fraud by establishing standardized claims forms and coding and unique secure identification numbers for all providers and patients. This will go far to eliminating the opportunities for multiple billing. Moreover, the Health Security Act authorizes an All-Payer Health Care Fraud And Abuse Control Program. The Act authorizes the Attorney General and the Secretary of Health and Human Services (through the HHS Inspector General) to coordinate prevention, detection, and control of fraud in all aspects of the reformed health care system. The HHS OIG will be able to apply its experience fighting health care fraud in Medicare and Medicaid to combating fraudulent schemes in any health care system. The Act specifically authorizes the Attorney General and the Inspector General to facilitate the enforcement of the new and existing statutory remedies applicable to health care fraud and abuse and arrange for the sharing of data and resources with federal, state and local law enforcement agencies, State Medicaid Fraud Control Units and state agencies with licensing and certification responsibilities. By instituting an all-payer health care fraud program, with the sharing of data and resources, the Act removes many of the program-specific limitations which have frustrated many law enforcement agencies confronting health care fraud, and thereby fosters interagency collaboration.

Second, the Health Security Act provides strengthened criminal, civil, and administrative remedies for health care fraud, which will give prosecutors new tools to stop health care fraud, punish its perpetrators and recover funds for the government and other victims. These provisions create a new general health care fraud offense prohibiting schemes to defraud any health alliances, plan or person in connection with the delivery of or payment for health care. At present, a general federal health care fraud offense does not exist. State health care prosecutions, while they are important and must continue, will never be an adequate response to health care fraud. A prominent federal role is warranted in health care fraud enforcement as with all white collar crime such as savings and loan fraud, securities fraud, and computer fraud. The federal government has more advanced resources to detect and pursue health care fraud such as computers and personnel experienced in detecting complex

financial schemes. In addition, the federal government is better able to deal with sophisticated schemes that often cross state lines. This new offense does not criminalize innocent billing errors by providers or inadvertent patient mistakes; it reaches knowing schemes to defraud. With the enactment of a federal health care fraud offense, Congress can make a strong public statement against health care fraud similar to the action taken with the enactment of a bank fraud offense in the Financial Institutions Reform, Recovery and Enforcement Act of 1989.

In addition to the general health care fraud offense, the Act includes specific offenses targeting the types of fraud which may emerge under any reform: false statements in matters involving health alliances or plans; bribery and graft in connection with health care; theft or embezzlement in connection with health care; and misuse of health security cards or unique identifier numbers. Any health care reform must include provisions targeting likely new fraudulent schemes. Only the Health Security Act meets this test.

Of course, not every fraudulent scheme merits criminal prosecution. However, given the present array of sanctions, the Department of Justice too often will be forced to choose between criminal prosecution or no sanction at all. The Health Security Act fills that void. It amends the False Claims Act to cover false statements presented to health care plans and alliances. The anticipated future configuration of the American health system necessitates this proposed amendment. Most Americans will receive health care from health plans which will mingle federal and private funds. This provision ensures that false statements to such plans will receive the appropriate attention.

The Act facilitates civil fraud cases by providing civil prosecutors of health care fraud the same tools available to civil prosecutors of bank fraud: namely, access to grand jury material. The Act also upgrades civil monetary penalties and other administrative remedies to ensure that persons found guilty of health care fraud in one health care system such as Medicare cannot repeat their fraud in other systems such as CHAMPUS or Federal Employees Health Program.

A final issue in ensuring health care fraud enforcement involves the need for adequate resources. Health care fraud cases are extremely resource intensive. They are among the most document intensive of all white collar crime cases. Investigation of false billing cases, for example, requires extensive storage space, computer information management systems, and financial analysis. As computer billing frauds become more common, so must sophisticated—and expensive—electronic fraud detection.

The Health Security Act will enhance fraud control by providing a source of resources for anti-fraud efforts. Section 5402 establishes an Anti-Fraud Control Account to fund audits, inspections of health care programs and health care fraud investigations and prosecutions. This Control Account will be financed with the criminal fines, civil penalties and damages, administrative penalties and assessments imposed, and assets forfeited in federal health care fraud cases. The Control Account will not receive restitution recoveries, which will continue to go to the direct victims of health care fraud. In recognition that the Control Account must support the goals and priorities of the All-Payer Health Care Fraud and Abuse Control Program, the Control Account will be administered by the Attorney General and the Secretary of the Department of Health and Human Services, the same parties responsible for establishing the national health care fraud program. The numerous federal as well as state agencies involved in health care fraud control will be eligible to receive resources appropriate to their health care fraud and control effort consistent with the national program.

Unfortunately, we cannot establish a health care system which is 100 percent fraud proof. However, our chances to prevent, detect, and control fraud are improved dramatically because the Health Security Act includes a comprehensive fraud control program not as an afterthought but as a fundamental feature of the new health care system.

This concludes my prepared remarks. I will be pleased to answer any questions that you may have.

The CHAIRMAN. Mr. Mangano?

STATEMENT OF MICHAEL MANGANO

Mr. MANGANO. Thank you very much, Mr. Chairman. I am pleased to be here this afternoon with my colleague from the Department of Justice to discuss health care fraud and abuse.

Let me first begin by saying that most health care providers are honest individuals working toward improving the health and well-being of their patients. It is a small group of health care providers that are responsible for the fraudulent activities. Yet, fraud and abuse that does occur represents a serious threat. It costs our Nation billions of dollars each year. These costs increase health care premiums for everyone, and to the degree to which the health care programs are federally funded, they increase the cost to the taxpayers. In addition, health care fraud and abuse puts citizens at risk by exposing them to unnecessary, sub-standard medical tests, procedures and equipment.

Our written statement discusses the extent and types of health care fraud that we encounter in some detail. I can safely state that fraud permeates the system. It can be found in all areas of the country and is committed by all types of providers.

The types of cases we investigate range from simple false claims to complex schemes involving groups of people. Billing for services not rendered continues to be the most common type of fraud committed against the Medicare and Medicaid programs.

Frequently, our investigations also involve providers and suppliers who game the programs by unbundling and upcoding charges. We also have become increasingly involved in allegations of violations of the antikickback—

The CHAIRMAN. Explain for the record what you mean by "upcoding." I know what you mean, but it is important.

Mr. MANGANO. What that has to do with is a medical provider charging for a service that is really more intensive than the service that was actually provided.

The CHAIRMAN. And there is a code.

Mr. MANGANO. That is correct.

The CHAIRMAN. Explain what that is.

Mr. MANGANO. Medicare pays its bills according to the codes that physicians and other health care providers charge against that service. So a specific code identifies a specific service that is delivered.

The CHAIRMAN. A broken arm versus a heart transplant?

Mr. MANGANO. That is correct.

The CHAIRMAN. They are coded differently.

Mr. MANGANO. That is right.

The CHAIRMAN. You get remunerated differently.

Mr. MANGANO. Yes. Some codes get remunerated much higher than others. Typically, an easy example to think of that is the way we pay for patients in hospitals. It is paid on a diagnostic-related group basis. There are 279-plus different diagnoses that a person can go into a hospital and be charged against. A heart transplant would be one code, a broken arm would be another. The hospital will get the payment for the broken arm if billed for that.

The CHAIRMAN. When you say upcoding, it is picking a service that was not provided that there is a greater payback from the Government to the provider for?

Mr. MANGANO. That is correct.

We have also become increasingly involved in allegations and violations of the antikickback statute, which prohibits the payment or receipt of anything of value as an inducement for the referral

of Medicare or Medicaid business. Other scams investigated by our office including the charging for generic drugs at brand name prices and selling fraudulent or worthless medical products.

Since the creation of the Office of the Inspector General, we have been actively and aggressively involved in combatting fraud and abuse in the health care programs financed by the Department, principally Medicare and Medicaid. The OIG's activities are designed to accomplish three tasks: to reduce fraud and abuse through successful detection, investigation and prosecution of criminal and civil wrongdoing; to prevent fraud and abuse in Department programs by identifying and recommending corrective actions and to eliminate weaknesses that increase the opportunities for wrongful behavior; and to identify wasteful practices and more efficient practices that can lead to program savings and protect the financial viability of the trust funds.

With national attention now being paid to reforming our health care system, it is particularly an opportune time to consider how we improve our ability to combat fraud and abuse. Any health care reform plan should have strong fraud and abuse provisions. We believe that three major problems need to be addressed.

First, the health care reimbursement system should be simplified. Currently, there are so many different billing forms, medical coding conventions, provider and patient enumeration systems, rules of coverage, payment methodologies and claim processors that it is extremely difficult to detect and deter sophisticated fraud and abuse.

We need to standardize on a national basis how we enumerate the providers and patients, prepare and submit billing forms or electronic records for payment, coordinate benefits when multiple insurers are involved, and establish accountability for each participant in the health care system—patient, provider, processor and payer.

Moreover, these same kinds of changes will make it easier for the honest participants in the system by reducing the number and complexity of rules that have to be followed by eliminating unnecessary administrative activities and duplicate paperwork.

Second, statutes should be strengthened to protect citizens from those who defraud the health care delivery system. This action would mean not only improving authorities that currently apply to Medicare and Medicaid, but also establishing authorities that can be used to combat fraud perpetrated against private health plans. Currently, administrative actions such as civil monetary penalties and exclusions, as well as antikickback provisions, do not apply beyond Medicare and Medicaid.

Third, we support the establishment of a new funding mechanism for more aggressive enforcement in the health care system. We believe that it is appropriate to have those who defraud the system pay for greater enforcement. Several reforms that have been proposed would establish a special account to recycle monies recovered from those who defraud the health care system. Deposits into the account would include money recovered in health care cases, such as criminal fines, civil penalties and damages in cases brought under the False Claims Act, and administrative penalties

and assessments. Of course, restitution would continue to be made to programs and plans which suffered the losses.

In addition to addressing those three problems, it is critical that the total enforcement effort be well coordinated. There are numerous Federal, State and local enforcement groups with a stake in investigating and prosecuting health care fraud under health reform. The effort will not work unless everyone is working together to share data, expertise and resources. We have worked diligently to ensure that our efforts are well coordinated.

In closing, Mr. Chairman, we cannot afford to continue losing billions of dollars each year in health care fraud. Simplification, improved enforcement authorities, and a new funding mechanism are all necessary to address the growing problem.

That completes my opening statement and I would be happy to answer any questions you may have.

[The prepared statement of Mr. Mangano follows:]

PREPARED STATEMENT OF MICHAEL MANGANO

Good morning Mr. Chairman and members of the committee. I am Michael Mangano, Principal Deputy Inspector General for the Department of Health and Human Services (HHS). I am pleased to be here today to discuss the important issue of health care fraud and abuse. These are major problems that cost our nation's health care system billions of dollars each year, in addition they put citizens at risk by exposing them to unnecessary or substandard medical tests, procedures, or equipment. It will take the concerted efforts of Federal, State, and local officials to deal with these problems effectively.

HEALTH CARE REFORM

Mr. Chairman, this is a particularly opportune time to discuss health care fraud and abuse because of the national attention being paid to reforming our health care system. Any plan for health reform that does not address fraud and abuse is badly flawed. Three major problems must be addressed.

THE CURRENT HEALTH CARE SYSTEM

First, the health care reimbursement system should be simplified. Currently, there are so many different billing forms, medical coding conventions, provider and patient enumeration systems, rules of coverage, payment methodologies, and claims processors that it is extremely difficult to detect and deter sophisticated fraud or abuse. This is particularly true when schemes are perpetrated across both public and private sector insurance programs, where administrative systems and record keeping procedures may vary significantly. To make fraud and abuse harder to perpetrate, we need to standardize on a national basis how we enumerate providers and patients, prepare and submit billing forms or electronic records for payment, coordinate benefits when multiple insurers are involved, and establish accountability for each participant in the health care system—patient, provider, processor, and payer. Moreover, these same kinds of changes will make it easier on the honest participants in the system by reducing the number and complexity of rules that have to be followed and by eliminating unnecessary administrative activities and duplicative paperwork.

ENFORCEMENT RESOURCES

As part of a reformed health care system, we believe that serious consideration should be given to increasing the resources devoted to health care fraud and abuse activities. Additional resources would allow for more aggressive pursuit of defrauders and abusers. The limited resources that are available make it difficult to address sophisticated and complex schemes that defraud and abuse health care programs. Often these schemes are more than local anomalies, extending across State lines and even nationally. If resources are not available to identify patterns of waste and abuse as well as investigate and prosecute complicated cases, wrongdoers will be more apt to commit fraud in order to gain substantial financial rewards.

To enhance resources for combating fraud and abuse, we support the establishment of an All-Payer Health Care Fraud and Abuse Control Account. Funds for this account should include criminal fines imposed in cases involving Federal health care offenses, civil penalties and damages imposed in health care cases under the False Claims Act (other than funds awarded to a relator or for restitution), administrative penalties and assessments in health care cases (other than funds returned to original payers, such as the Medicare Trust Fund or the States), and amounts resulting from the forfeiture of property by reason of a Federal health care offense.

ENFORCEMENT AUTHORITIES TO PROTECT CITIZENS AND HEALTH PLANS

Several statutory improvements could be made to protect citizens and their health care plans from unscrupulous providers. We can build on our successful initiatives and remedies in the Medicare and Medicaid programs. First, we can make needed changes in statutes governing those programs and then enhance them to address fraud and abuse throughout the health care system.

Changes to Current Medicare and Medicaid Statutes—While we believe that we have been successful in combating fraud and abuse in the Medicare and Medicaid programs, certain statutory modifications could be made to decrease program abuses. These modifications include:

- Civil monetary penalties should be added for activities such as kickbacks, routine waiver of copayments (with appropriate exceptions, e.g., for low income individuals), and “upcoding.”
- The current Medicare ban on payments for physician self-referrals should be broadened to include any item or service not rendered by the physician personally or by a person under the physician’s direct supervision. Many of the existing exceptions should be revised, such as the in-office ancillary services, prepaid plans, and physician recruitment exception.
- The current permissive exclusion for individuals or entities convicted, in connection with delivery of health care items or services, of fraud or financial misconduct should be made mandatory. A criminal conviction related to delivery of an item or service in Medicare or a State health plan are currently the basis of a mandatory exclusion.

Enhancing Current Remedies to Address Fraud Throughout the Health Care System—While the Federal Government currently has many authorities to combat fraud and abuse in the Medicare and Medicaid programs, similar authorities to address abuses in private health plans do not exist. The following actions are among those that could resolve this discrepancy:

- Current civil monetary penalty authorities should be expanded to authorize the Federal Government to assess penalties against persons who engage in specified activities with respect to any health plan. The basis for these penalties should include, for example, false claims and false statements in claims, or false advertising to the public.
- Civil monetary penalties should also be aimed at managed care abuses that occur in all managed care plans. These abuses are very different than those that exist in fee-for-service medicine (where there is an incentive to order more services) and include “skimming,” which is discouraging the enrollment (or actually disenrolling) unhealthy patients or patients in high risk groups, or denying patients expensive care even when it is medically indicated.
- Current Federal exclusion authorities should be expanded to authorize HHS to exclude a provider from participation in all public and private health care programs.
- Current Medicare-Medicaid prohibitions on kickbacks and physician self-referral should be extended to all public and private payers. (Health care items and services that are paid on an at-risk, capitated basis do not have similar overutilization concerns. Therefore, any reform should include appropriate exceptions for certain managed care plans and capitated payments to providers.)
- A health care fraud criminal statute should be enacted. Since few criminal provisions directly address health care fraud, a new statute would serve as clear, explicit notice to all that this conduct is prohibited by specifically penalizing schemes to defraud either public or private health care programs.
- The False Claims Act should be expanded to cover claims presented to all health plans. The civil provisions of the current False Claims Act cover claims submitted to the Government.
- A data base of all final adverse actions against health care practitioners should be established with appropriate safeguards for privacy and access.

COORDINATION

In addition to addressing these three problem areas, it is critical that the total effort be well coordinated. There are numerous Federal, State and local law enforcement groups with a stake in investigating and prosecuting health care fraud. These include the Department of Justice and the Federal Bureau of Investigation; the Inspectors General at HHS, the Department of Defense, the Department of Labor, and the Department of Veterans Affairs; the United States Postal Service, State Medicaid Fraud Control Units and State Attorneys General; and HCFA's Medicare contractor fraud units. Only by working together can we effectively use the resources of these various entities to combat fraud and abuse. This coordination must include the sharing of data, expertise, and resources.

The Federal and State agencies involved in combating health care fraud and abuse are *not* waiting for the enactment of health reform legislation to coordinate our enforcement efforts to the greatest extent possible. The HHS/OIG is working to consolidate direction of all functions funded wholly or primarily with HHS funds, including the 42 State Medicaid Fraud Control Units, and the 65 newly-established Medicare Contractor Fraud Units at the Medicare carriers and intermediaries. We are also working with law enforcement officials outside of our Department. Last November, we worked with the Department of Justice to establish an Executive Level Health Care Fraud Policy Group. The group includes representatives of the Attorney General's office, the Civil and Criminal Divisions of DOJ, the FBI and OIG. We have been working to identify new methods of proceeding against health fraud, identifying priority areas for increased enforcement, and breaking down red tape barriers. Finally, we and the other Inspectors General have formed an IG Health Fraud Coordination Council to better handle fraud problems that affect the programs of our respective Departments.

We have also looked beyond the government to prevent waste and deter fraud and abuse. Until recently, private health insurance programs had no significant investigative response to fraud. To address this issue, in 1985 we helped launch, and were one of the founding members of, the National Health Care Anti-Fraud Association (NHCAA). This association currently has 660 members and consists of nine public sector entities including our office, Medicaid Fraud Control Units, and 52 private sector entities. These members share information (with appropriate legal safeguards), engage in public education on health care fraud issues, train members and non-members through regional conferences, seminars, and workshops, and serve in an advisory capacity to industry, regulatory, and legislative bodies. In addition to working on joint projects with this group, we help train the members in better detection techniques and alert them to new types of health fraud.

Let me now describe to you in greater detail the nature and extent of the problem of health care fraud and abuse and what we do to counteract it in the Department of Health and Human Services.

EXTENT AND TYPES OF HEALTH CARE FRAUD AND ABUSE

Recently, the rapid rise in health care expenditures and problems associated with access have attracted unprecedented attention and scrutiny. This attention has also brought about discussions regarding the magnitude and pervasiveness of fraud, waste, and abuse.

In examining monetary losses to health programs, some distinction should be made among fraud, abuse, and waste. Although frequently one problem or failing involves all three, we use the following rough definitions:

- Fraud is the obtaining of something of value through intentional misrepresentation or concealment of material facts.
- Abuse is any practice that is not consistent with the purposes of providing patients with services which (1) are medically necessary, (2) meet professionally recognized standards, and (3) are fairly priced.
- Waste is the incurring of unnecessary costs as a result of deficient practices, systems, or controls.

It is extremely difficult to estimate the total monetary loss as a result of fraud in the health care industry. I note that our jurisdiction is over the Medicare and Medicaid programs and we have conducted numerous analyses in specific areas of these programs and have found substantial losses. For example, we know from our reviews of the Medicare secondary payer program that Medicare had inappropriately paid upwards of a billion dollars annually that should have been paid by private insurers. Similarly, after we identified problems associated with hospital credit balances, HCFA took corrective action that recovered in excess of \$500 million. We can also tell you the more we look the more areas of fraud and abuse we find. Thus

we can state with certainty that fraud and abuse associated with health care in this country is in the billions of dollars.

TYPES OF FRAUD AND ABUSE

Over the years, the types of health care fraud confronted by our office has changed. In the 1970's, we found that we were largely dealing with individual providers who were involved in relatively uncomplicated schemes, such as filing false claims which resulted in a few thousand dollars of damage to the Medicare program. Today, it is more common to see cases involving groups of people who defraud the Government. Some of the schemes are relatively complex, often involving the use of sophisticated computer techniques, complicated business arrangements, and multiple locations across State lines. These crimes can cause losses in the tens of millions of dollars to Medicare and Medicaid, as well as to other public and private health insurance programs. As our health delivery system evolves we can expect to confront different types of fraud and abuse.

Because of the limited time we have today, we have selected a few examples of fraudulent and abusive practices that will give you a broad overview of the types of cases investigated by our office. The following types of fraudulent activity are among those most prevalent that we investigate (some of the case examples involve multiple abuses):

Billing For Services Not Rendered—Most of our workload continues to involve billings for services not rendered. These cases are more readily accepted for prosecution by the United States Attorneys and are responsible for the bulk of the convictions obtained in the health care field. The following cases are examples of recent successful prosecutions involving billing for services not rendered:

- A California man illegally received almost \$1 million by using various physicians' provider numbers to bill Medicare for blood circulation tests he never performed. He diverted notices of payments to 38 mail drops he controlled by putting false beneficiary addresses on the claims.
- The owner of a durable medical equipment company in Ohio solicited orders for seat lift chairs through a telemarketing firm, collected \$300 to \$600 from Medicare beneficiaries—many of whom were disabled-billed Medicare, but never delivered the chairs.
- An Illinois psychiatrist had to repay \$300,000 to Medicare and Medicaid for submitting claims that indicated he was working more than 24 hours a day.

Misrepresentation of Services Rendered—The Medicare program loses money when providers submit claims that do not reflect the services actually performed or the supplies actually delivered. Some providers try to "game" the program by unbundling and upcoding charges. Unbundling is the billing of the subcomponent parts of an item or service rather than the complete item or service in order to inflate charges far above the appropriate level. Upcoding is the practice of billing for a more intensive service than the one actually delivered. The following cases are examples of recent successful prosecutions involving inaccurate claims:

- National Health Laboratories, Inc. (NHL), one of the nation's largest clinical laboratories, purposely designed its laboratory forms and billing procedures to induce doctors to order unnecessary laboratory tests. The company added two tests every blood chemistry panel test ordered by a physician. Doctors were led to believe that the extra tests cost little or nothing. However, because Medicare and Medicaid claims are submitted directly to those programs by laboratory companies, the programs were billed high prices for the tests, a fact unknown to the doctors. Following the government's investigation, NHL and its president were convicted of fraud, and the total amount paid by NHL to the government in settlement was \$110 million. In addition, the president of NHL served time in jail for his activities. A similar case was settled with MetPath and MetWest, for approximately \$40 million.
- A Minnesota psychiatrist billed Medicare, Medicaid and the Department of Veterans Affairs for more than \$60,000 for extensive psychotherapy and visits with patients in nursing and board and care homes whom he did not see or saw only in groups at meals and snacks.
- A Florida ophthalmology group paid \$2.5 million to resolve claims arising from two Medicare billing schemes. In one scheme, they billed for services under an erroneous code to obtain maximum reimbursement for laser surgeries. In the other they contracted with a billing service which resubmitted to Medicare claims for individual procedures already reimbursed under global payments.

Kickbacks and Physician Self-referral—A widespread problem in the fee-for-service area is the problem of kickbacks and physician self-referral. A kickback is the payment or receipt of anything of value as an inducement for the referral of health care business. Physician self-referral is an overlapping and similar problem. Physician self-referral is the referral for any item or service to an entity by a physician who has a "financial relationship" with that entity, and where the physician does not directly provide the item or service. The overall concern within kickbacks is that financial, rather than medical, factors may affect physician decisions about providing patients medical care. Since 1987, we have received more than 1,967 allegations of violations of the anti-kickback statute, and have opened over 1,194 cases involving 2,099 individuals. Over 716 convictions, settlements, and exclusions have been obtained as a result of our investigations, as well as almost \$25.5 million in monetary recoveries. The following are examples of recent successful prosecutions involving kickbacks:

- In 1986, a retired electrician from Chicago had a "mystery pacemaker" implanted in his chest. One could not determine the brand, serial number or even the expiration date of his pacemaker or the lead attached to his heart. The patient did not know his pacemaker was subject to failure, which would require a pacemaker replacement operation with all the attendant risks of surgery. Hundreds of other elderly patients in the Midwest also received mystery pacemakers. Why did the patient's cardiologist implant such a pacemaker? The cardiologist admitted that he received the services of a prostitute, a trip to Hawaii and other types of kickbacks from the pacemaker dealer. That dealer and nine others were convicted for misbranding pacemakers, changing their expiration dates, giving kickbacks and/or overcharging.
- A chiropractor and his wife in Georgia had to repay Medicare and more than 30 insurance companies over \$2.2 million for a scheme in which employees and some 40 patients were paid a percentage of reimbursement for treatments, many of which were never done. In one instance bills were submitted for 169 persons supposedly treated in one day.
- A total of sixteen physicians, two physician assistants, three office managers and the owner of a durable medical equipment company were convicted in Florida for paying or receiving \$50 to \$300 each in exchange for prescriptions for oxygen concentrators or nebulizers. The company owner was ordered to repay \$3.8 million to Medicaid.

AREAS OF FRAUD AND ABUSE

While these types of fraudulent activities can permeate all aspects of the health care system, we have devoted significant resources to areas that appear rife with abuse. These areas include home health agencies, psychiatric clinics, clinical laboratories, home infusion, and durable medical equipment. These areas are described in more detail below.

Home Health Agencies—Home health agencies (HHA) provide care in the patient's home, with limited supervision by an attending physician. Several kinds of fraud occur in HHA operations: cost report fraud; excessive services or services not rendered; use of unlicensed or untrained staff; falsified plans of care and forged physicians' signatures; kickbacks; and intermediary hopping. Since 1986, we have concluded 29 successful criminal prosecutions of HHAs and their employees. Since 1991, we have excluded 27 HHAs, owners or employees from participating in Medicare.

Psychiatric Services—There are approximately 700 psychiatric hospitals participating in the Medicare program. Program funds exceed \$2.5 billion annually for inpatient psychiatric care. Our investigations lead us to believe that the major concern is the medical necessity of lengthy hospital stays. We are also concerned about kickbacks and other incentive arrangements between the hospitals and practitioners ordering psychiatric hospitalization. In a scheme we saw recently, hospitals paid physicians up to \$2,000 for each patient referral. The clinics included payment to doctors in their cost reports they submit to Medicare. The payments doctors received were ostensibly for writing manuals for the clinics to use in the care of patients, but these manuals were never written. The OIG has several ongoing investigations (with the FBI) of psychiatric hospitals.

Clinical Laboratories—Our investigations into clinical laboratories indicated that the major fraud in this area is over-utilization. The laboratories bill the Medicare program directly and beneficiaries are not liable for any cost sharing. As a result, neither physicians nor beneficiaries have adequate information or incentive to monitor utilization or costs. The marketing of tests by laboratories also encourages their over-utilization while maximizing reimbursement from Medicare and Medicaid.

Many tests are performed on automated equipment capable of conducting multiple analyses on a single specimen. While the profiles are marketed to non-Medicare users as a single product, we are concerned that some laboratories unbundle the tests by billing Medicare for individual tests. Program expenditures for clinical laboratories was over \$1.7 billion dollars in 1993. In the last 3 years, eight convictions have been obtained as a result of our laboratory investigations.

Home Infusion—Home infusion is one of the fastest growing segments of home health care in the U.S. (about \$4 billion annually), and is still in its infancy as compared to other home care services. We believe that kickbacks in the form of case management fees or fees for service are used as incentives for physicians to refer patients to a particular company. Payment averages \$150 per week per patient. Doctors have made \$10,000 per month in kickbacks. Kickbacks are disguised as service agreements, research grants partnerships, stock options, and dummy corporations. We have received a number of additional allegations in this area including unbundling, ghost patients, nutritional needs that fall short of those needed to sustain life, and "diverted" drugs and nutrition used in infusion therapy.

Durable Medical Equipment (DME)—For many years, we have issued reports documenting fraudulent, abusive and wasteful practices in the DME area. Seat lift mechanisms, transcutaneous electrical nerve stimulators (TENS), oxygen equipment, home dialysis systems and similar equipment are reimbursed by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this requirement through aggressive sales practices, tricking physicians into signing authorizations and even forging their signature. Some suppliers simply bill for items never delivered; others bill carriers in States which pay high Medicare reimbursement, regardless of where the sale took place. In the last 3 years alone, over 73 convictions have been obtained in this area. We are pleased that the Department is currently undertaking reforms which will change point-of-sale rules and how provider numbers are issued.

HHS ANTI-FRAUD AND ABUSE ACTIVITIES

The Department of Health and Human Services (HHS) is the Federal Government's principal agency for promoting the health and welfare of Americans and providing essential services to persons of every age group. The Department's two largest health programs are the Medicare and Medicaid programs, which are administered by the Health Care Financing Administration (HCFA). Medicare provides health insurance coverage to approximately 36 million beneficiaries aged 65 and older and to certain disabled individuals. The Medicaid program provides grants to States for the medical care of approximately 35 million low-income people. Expenditures for the Medicare program will total about \$158 billion this year and expenditures for Medicaid will reach approximately \$150 billion (\$87 billion Federal share).

Created in 1976, the OIG is statutorily charged to protect the integrity of departmental programs, as well as promote their economy, efficiency and effectiveness. We meet our challenge through a comprehensive program of audits, inspections, and investigations. The activities of our office consist of a multi-faceted approach to improving the management of the Department's programs and protecting the beneficiaries from fraud, waste, and abuse. Over the years, the Medicare program has seen significant reforms, many of which resulted from issues brought to light by the OIG. Such reforms include implementation of a prospective payment system (PPS) for inpatient hospital services and a fee schedule for physician services, the Clinical Laboratory Improvement Amendments of 1988, regional consolidation of claims processing for durable medical equipment (DME), establishment of fraud units at Medicare contractors, prohibition on Medicare payment for physician self-referrals, and new payment methodologies for graduate medical education.

We are also very active in analyzing the cost-effectiveness of services delivered. Over the years, we have documented excessive payments with respect to hospital services, indirect medical education payments, durable medical equipment, and laboratory services. Our recommendations have led to statutory changes to reduce payments in these areas. Through these activities, we have sought to ensure that program dollars are spent without undue waste and that the financial viability of the trust funds is maintained.

We are equally concerned that the beneficiaries of our programs receive high quality care. Over the years, the OIG has assessed clinical and physiological laboratories, medical necessity of certain services and medical equipment, and various State licensure and discipline issues. We have also reviewed several aspects of medical necessity and quality of care under the prospective payment system, including the risk of early discharge. Finally, we looked at the quality of care provided by itinerant surgeons, and surgery provided in physician's offices.

We also evaluate the adequacy of internal controls that are both in place and planned to prevent losses to fraud, waste, and abuse. We carry out these evaluations by: reviewing internal controls as part of our audits of the financial statements issued under the Chief Financial Officer's Act of 1988; and working with HCFA in planning, development, and implementation of new claims processing and management information systems to help assure adequacy of program safeguards on a national basis.

Our investigative role is aimed at reducing and preventing fraud and abuse and ensuring that beneficiaries receive high quality care at appropriate payment levels. We utilize three enforcement authorities: (1) criminal prosecution, (2) civil prosecution, and (3) administrative sanctions (which include both program exclusions and civil monetary penalties). All investigations can result in one or more of these remedies being employed. We refer investigative findings directly to the United States Attorneys for possible criminal or civil prosecution. Once the Department of Justice has completed or declined a criminal or civil prosecution, HHS can impose civil monetary penalties pursuant to the Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a. The OIG is also responsible for implementing the Secretary's authority to exclude fraudulent or abusive providers from participation in Federal health care financing programs. Our authorities are described in more detail below.

Criminal Authorities—Federal prosecutors seek to redress health care fraud by using traditional criminal authorities, including mail and wire fraud statutes, and the false claims and false statements statutes. Congress also has enacted criminal statutes directed specifically to prevent fraud and abuse within Federal health care programs. Such authorities include criminal penalties for false claims and statements specifically involving the Medicare and Medicaid programs, and the Medicare and Medicaid anti-kickback statute. The anti-kickback statute prohibits an individual or entity from offering, paying, soliciting, or receiving remuneration with the intent to induce Medicare or Medicaid program business or in return for the referral of this business.

Civil Authorities—Federal prosecutors also rely on civil authorities to combat health care fraud and abuse. Foremost are the civil provisions of the False Claims Act which authorize the Federal Government to recover treble damages, costs, and a civil penalty of between \$5,000 and \$10,000 for each false claim.

Administrative Sanctions—The Department enforces two types of administrative sanctions in the Medicare and Medicaid programs: civil monetary penalties (CMPs) and program exclusions. In 1981, Congress authorized HHS to impose CMPs, assessments, and program exclusions on individuals and entities who submit false or improper claims for Medicare or Medicaid reimbursement. Since the first CMP was enacted in 1981, Congress has greatly expanded this authority. HHS has had the authority to exclude from participation in Medicare and Medicaid any health care providers and practitioners determined to have engaged in fraudulent or abusive practices since 1972. The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, and controlled substance abuse, as well as for revocation or surrender of a health care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse.

The record shows that we have been successful. Overall, in fiscal year 1993, the Office generated savings, fines, restitution, penalties, and receivables of over \$61 for each Federal dollar invested in our operation. The number of providers and practitioners excluded from program participation increased from 224 in fiscal year 1983 to 881 in fiscal year 1993. And while six civil monetary penalty (CMP) cases were successfully settled by the OIG in fiscal year 1983, the number rose to 75 cases in fiscal year 1993. Successful health care prosecutions in the criminal courts have also dramatically increased, from 30 in fiscal year 1983 to 181 in fiscal year 1993. I would also point out that OIG administrative actions are subject to review by Administrative Law Judges. Sanctioned individuals can appeal these decisions to the Departmental Review Board and through the Federal court system. Of the more than 7,600 program sanctions imposed by the OIG during the past 10 years, only a very few have been reversed.

MEDICAID FRAUD CONTROL UNITS

The OIG and the State Medicaid fraud control units (MFCUs), have concurrent investigative authority in the Medicaid program and conduct joint investigations. The MFCUs, supported largely (75-90 percent) by Federal dollars, devote approxi-

mately 1,200 personnel to investigating Medicaid fraud. Currently, Federal outlays for operation of the MFCUs are approximately \$69 million. The units reported 628 convictions in fiscal year 1993 with total recoveries of over \$41.6 million. Approximately 25 percent of their caseloads involve patient abuse allegations, for which there is no monetary recovery.

HCFA MEDICARE CONTRACTORS

The OIG works closely with HCFA and the Medicare contractors that process Medicare claims and perform payment safeguard functions. As a result of our recommendations over the last several years, HCFA initiated a broad effort to get the Medicare contractors to take a more active role in detecting, developing and referring potential fraud cases to the OIG. Among the changes that HCFA implemented was the creation of fraud units within most Medicare contractors. To date, 65 Medicare fraud units have been established, including units for the four regional claim processing contractors for durable medical equipment. These units are funded at approximately \$32 million and employ about 450 people. We believe that this will create a significant increase in quality case referrals to our office from the contractors.

CONCLUSION

As the Congress and the Nation contemplate changes to our health care system, the problems of fraud, waste, and abuse must be addressed. In my opening remarks I identified the three fundamental problem areas which we believe need attention: simplification of the current health care delivery system; enhanced enforcement resources; and enactment of strengthened enforcement authorities to protect citizens and health plans. We believe that any health reform legislation enacted by the Congress should address all three concerns.

This concludes my prepared testimony. I would be happy to answer any questions that the committee may have.

The CHAIRMAN. I thank you both. With the permission of my colleagues, maybe we can go in 10-minute rounds, if that is OK.

Let me begin with you, Mr. Stern. First of all, I think the President has made a real contribution in the legislation that has been submitted, but I have two questions in areas that I have dealt a lot with in the criminal justice field that have not related to the health care fraud portion.

The first is in the prohibition of kickbacks. The reason I put that chart up there is—I am preaching to the choir here; I know you both know all this better than I do, but it leads to my question.

The people who actually expend the money to pay—54 percent of that comes from private insurance, private payers. As you can see on the chart there, you have from Federal Medicare and Medicaid 23 percent; State Medicaid, 6 percent; and other State and Federal expenditures, 18 percent.

Now, as I understand the antikickback provision that is in the law now and in the President's proposal, in his bill, it, in fact, makes kickbacks illegal in all the situations except the red. Well, I am being corrected, rightly, by my staff. He is fired. [Laughter.]

That is a joke. I was only kidding. The reason I said that is he is brand new, he is very competent. [Laughter.]

But he is correct in that it relates to Federal Medicare and Medicaid, but it does not apply to the red and it does not apply to the yellow, and apparently does not apply to the blue. It only applies to the shaded green areas. So there are an awful lot of expenditures that are made in the system to which the antikickback provision does not apply.

I have two questions. One, why? And, two, is it because there is not a problem in terms of kickbacks in the other nonfederally-funded portions of health care expenditures?

Mr. STERN. Well, first, it is a problem. In fact, we see examples where, because it now is prohibited with Federal Medicare and Medicaid, some of the providers may actually intentionally structure what they do to have the kickbacks occur in the private area and not have them occur in the Federal area because they are concerned about our criminal prosecution.

I think, to clarify our intention, we should have the Federal antikickback statute in this health care fraud provision to provide it across the board. This is an all-payer system that we are dealing with, and to be consistent we should have an all-payer——

The CHAIRMAN. I agree. Is that how the legislation is now written, though?

Mr. STERN. It needs to be clarified.

The CHAIRMAN. Yes. Well, I hope so because I fully concur in your assertion that because you have the green shaded area protected, in effect, there are very sophisticated ways of doing the same thing through the private kickback area.

Now, again, I want to make it clear to the public who is listening to this, because it is confusing, the kickback relates to a referral. If you refer to such-and-such a doctor, program, or treatment, you get something in return for that.

I am glad to hear you say that. This committee is anxious to work with you. At least to speak for myself, as chairman of the committee I am anxious to work with you to make sure that that is clarified.

Now, there is a second area. Back in the 1970's, I wrote a bill that became known as the forfeiture legislation. At the time, I was trying to deal with organized crime, and I was chairing a subcommittee here that dealt with organized crime. It has turned out to be, as my colleagues both know because they have been deeply involved in this, an incredibly effective tool, where the proceeds go back to police agencies in order to reinvest in investigative, as well as prosecutorial pursuits, of the very people whose property we have confiscated or forfeited, and all the civil liberties are protected.

There has been some argument that in drug cases it has been egregious, but by and large it is a tool the police have loved and used well, as well as a tool that law enforcement generally, and prosecutors and all involved, have viewed as a very useful tool.

Now, you have a provision in the President's legislation, as I understand it, where forfeiture, unlike in my criminal forfeiture stuff that we started back in the 1970's, is limited only to certain circumstances where there has been an indictment and a conviction.

Right now, if we indict and convict a drug lord and we can make the nexus between the profit he made from these sales and the fact that he owns a multi-million-dollar mansion, yachts, et cetera, we can confiscate the yacht, the mansion, et cetera. But here, as I understand it, first there must be an indictment; second, a conviction. Third, a Federal judge would have to determine, on his or her own accord, that it was a particularly serious crime, not that there was, in fact, not just a crime, but a serious crime.

Now, why not just follow the pattern we have followed, I think, successfully in other criminal prosecutions with regard to the forfeiture tool?

Mr. STERN. The simple answer is that we have a forfeiture act 1994 that we are going to be presenting which will basically say what you are saying about all proceeds of Title 18 crimes should be forfeitable. I think this is an inadvertent inconsistency in this particular proposal with our more general proposal, and I think we would prefer to go with our more general proposal which would specifically provide that all proceeds of the crime would be forfeited, as they should be.

The CHAIRMAN. Good. Well, I am glad to hear that because, as you know, I share that view strongly and it has been a very useful tool. Nothing seems to get the attention of people like the notion that not only are they potentially liable for time in jail, but that you can go and get their assets.

It is a useful tool for you, sir, if you have that additional funding available to you. Is that not correct? I mean, it can be a very important tool.

Mr. MANGANO. Absolutely.

The CHAIRMAN. Now, my last question to you, Mr. Stern, before my time runs out. I notice that the legislation rightly allows, in my view, the Attorney General to seek injunctions to stop ongoing fraud. Is that correct?

Mr. STERN. That is correct.

The CHAIRMAN. Now, that power is always, at least in the past, accompanied by an additional power to freeze assets. You get the injunction and you freeze the assets of the outfit or individuals against whom you have got the injunction. The reason for that is obvious, so that there is some chance of getting some of the money back when the case is finally thoroughly investigated and prosecuted if there is a plea or a conviction.

Now, again, I may be mistaken, but the President's bill seems not give you and the Attorney General's office that additional power, which is to freeze the assets. A, am I right? And, B, if I am, why not?

Mr. STERN. Actually, we believe we have that power now. U.S. attorneys throughout the country have interpreted the statute that is there at present to allow them to seek to freeze assets when they go in for an injunction. So we believe that with the specific authority now to seek injunctions for health care fraud directly as opposed to indirectly, as we now do it, we would carry along the authority to freeze assets. Again, if that needed to be clarified, we would have no objection to the clarification.

The CHAIRMAN. Good. My time is up, but I happen to be a supporter of the President—Senator Cohen's proposal that is part of the—

Senator COHEN. You are joining a long line of advocates that I step up to that. [Laughter.]

The CHAIRMAN. That is right, I am. Believe me, if there has to be a Republican President, I would like it to be you, Senator Cohen.

All kidding aside, we have included a very important provision in the crime bill. One of the arguments is that it is better—and in a rational sense, it is better to do it all in one piece of legislation, and with that I agree. I have two concerns. One is that we get one piece of legislation passed this Congress. If the good Lord would

come down and guarantee me what I wish to happen is going to happen, then I would be more inclined to wait and see.

But the proposition that we should include everything in one fell swoop here dealing with this area seems to me argues that we should make the clarifications explicitly on forfeiture, on freezing assets, and on kickbacks that I think, based on your testimony, we agree on. So although you don't need the expertise of this committee, I would be willing to work with you and come up with some language that you either incorporate or that we could recommend, but I want to do it in conjunction with the Justice Department, as to how to accommodate the three things we spoke about today.

Mr. STERN. Thank you very much.

The CHAIRMAN. Thank you.

Senator Grassley?

STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM THE STATE OF IOWA

Senator GRASSLEY. The chairman spoke about the forfeited assets that could be used to finance this, and the President has monetary recoveries, the fines, et cetera, that are going to flow to the general Treasury, not to the investigative agencies, such as the inspectors general, et cetera. I have heard that in Florida, for instance, there may only be three or four investigators on Medicare fraud.

Why is it important that the recoveries be set aside to be used by these agencies rather than going to the general Treasury to be appropriated back?

Mr. STERN. Well, it is a supplement, to start with. It is not the major way in which we are going to get the resources to fight health care fraud. That will be continually the prerogative of the Congress when they authorize our appropriations.

The idea here would be to have some flexibility to deal quickly with areas in which we may need to put in more resources, more funds; a computer, for example. We heard a case just yesterday where we were looking at a particular State where there is a problem and somebody then turns to us and says, well, we need a computer to work with all this data; who is going to buy that for us?

It would be nice to have some supplemental funds here from those who committed the wrongdoing to be used to prosecute others who are committing the wrongdoing. But, again, it is not the major source of the resources that will be necessary in our battle in health care fraud.

Senator GRASSLEY. But it certainly is a beneficial supplement to give you more flexibility.

Mr. STERN. We certainly would like that.

Senator GRASSLEY. And you see it as a very important tool for accomplishing your investigatory responsibilities and prosecutions, et cetera?

Mr. STERN. Yes, sir.

Senator GRASSLEY. On another matter, since you have discussed the limited public resources available to fight health care fraud, I want to remind you that since 1986 when the False Claims Act was amended, there has been almost \$900 million recovered under the qui tam provisions of that false claims bill.

While many of the early cases involved Defense contractors, it seems like there is a trend toward using that as a tool in health care fraud. We may see hundreds of millions of dollars recovered from health care fraud qui tam suits in just the next few years. I happen to believe that qui tam is a much-needed backup to the Government's own health care fraud efforts. I think it offers us an opportunity to combine insider information with private resources.

What are your thoughts on qui tam? Would you agree that it is a valuable tool to combat health care fraud because it assists public prosecutions and other enforcement efforts with private resources?

Mr. STERN. It has been a very important source of cases for us in the health care fraud area, and I think you are absolutely correct, Senator Grassley, that it is increasingly being used now as people see other cases which have brought great benefit not only to the relaters, but to the Government. So we very much favor the use of the qui tam False Claims Act procedures with respect to health care fraud.

Senator GRASSLEY. Are there any ways that you believe that the public-private partnership of government resources, and also including qui tam, to fight health care fraud can be made more effective?

Mr. STERN. Well, I do understand that there is at the Justice Department now an ongoing review of certain amendments that you all are considering with respect to qui tam. I am not working on that myself directly, so I am not able to answer directly on that, Senator Grassley, but I do want to reiterate how important I do think the qui tam legislation has been to date in the health care fraud area.

Senator GRASSLEY. Well, I guess at this point I thought you might have some. If you don't have any, that is perfectly legitimate. Let me just suggest to you that I would be very happy to work with you to develop a more cooperative effort in anything that can be done to enhance private sector resources with government resources.

Let me also comment that you are right that we are working with your department to improve qui tam, but I think the things that we are talking about there would be more fine-tuning, and what I am talking about in my question to you would be ideas that are not working their way through the bureaucracy yet that might be helpful.

Also in the process of reforming qui tam, remember that there are a lot of organizations out there, particularly connected with the military industrial complex, that want to really weaken the bill. So we are going to have to proceed cautiously on that, but I would look forward to any suggestions you might have.

I have heard of some individuals who have received notices that Medicare has been billed for services or products twice, or for services that were not received. I have heard that these very same people have attempted to notify HCFA, but that the notice of claims and payments keep coming anyway. Even though people tell the bureaucracy about the problems, it seems like the problems don't stop.

How can Health and Human Services better address the reports of health care fraud that are brought to your attention by individ-

uals? I think, Mr. Mangano, you might be the best one to answer that. You are aware of the problem, I am sure.

Mr. MANGANO. Yes; we have heard accounts like this. Typically, what happens is a beneficiary gets a bill that isn't right. It is a duplicate bill or charges for services that they know they did not receive. The beneficiary will call what is called the Medicare contractor. This will be the insurance company that is paying the bills for the Medicare program.

Just in the last couple of years, the Medicare program has started to put into place Medicare fraud control units. They are now in existence at 65 locations across the country, with about 450 staff. We have been working with those groups over the last 2 years to train them in how to develop that information and make that referral over to our office. We are getting more and more good leads on cases that we will then develop after they provide us the information that they have been wrongfully billed.

Senator GRASSLEY. As a follow-up not directly related to what I asked you, but in this whole process—and this would be one example of fraud where qui tam could be used—do you in your department see qui tam as an important tool?

Mr. MANGANO. Yes, we do, and we have investigated a number of cases that have involved qui tam and brought them to some very successful conclusions.

Senator GRASSLEY. Mr. Stern, your testimony described an important increasing role of the FBI in fighting health care fraud. Yet, I know that there has not been a single new FBI person hired since 1992. As far as I know, we don't expect to hire any new agents in the near future. What is your view of the wisdom of cuts that have brought this situation about, and how do you think the cuts will affect the FBI's ability as an effective fighter of health care fraud?

Mr. STERN. Well, first, the FBI did make health care fraud an important initiative back in 1992, I think, and their work-year numbers—I might just quickly give you those. It shows in 1991 they had 71 FBI work-years doing health care fraud. As of 1994, they are now at 228 annualized work-years. There are, in fact, 613 individual agents now assigned to health care fraud; that is, they might have one or more cases in the health care fraud area.

I have gone around the country now with the number 5 man of the FBI—I would list all the cities; it would be too long to list—but everywhere in this country, from east to west and north to south, meeting with health care fraud working groups that are being created like the ones I mentioned to you in Des Moines and energizing the FBI effort to work on health care fraud.

They predict that from the 228 they are now at, they will be going up to 440 work-year agents doing health care fraud, and increasing their support personnel from 97 up to 211. So there is a large movement of FBI effort into the health care fraud area. Some of it is coming from other areas where they felt they didn't need the agents as much as they used to in the past. Some is coming from an effort to reallocate some of the folks from the financial fraud area into health care fraud.

As you indicated, Senator Cohen, health care may be for the 1990's what financial institution fraud was for the 1980's. We are

trying to reallocate to make certain that we have our people in the right place.

Senator GRASSLEY. So the cuts in appropriations, then, haven't diminished your work in this area. You have been able to reorganize resources, right?

Mr. STERN. We are doing that. I note that the FBI has asked for an increase, but we are trying to deal with the resources we now have to allocate them in the proper place, and we think health care fraud is one of the areas where we should be doing that.

Senator GRASSLEY. I thank both of you.

The CHAIRMAN. Senator Cohen?

Senator COHEN. Well, first, let me thank my vice president, who has since departed from the room, for his comments. I misspoke; I said there was a long line advocating. There is a very short line. In fact, he is the first one in line, both parents and family dissenting.

Let's assume there is no health care reform plan in the offing; there is no Clinton plan, there is no Chafee plan, there is no Cooper-Breaux plan, there are no plans. Would it be your judgment that we should not do anything to adopt a health care fraud offense statute? I mean, assuming there is nothing in the works for reforming the current health care system, isn't there a compelling case to be made that we should adopt the basic provisions that are found in the Clinton plan or the Chafee plan or the Cohen plan or any of the others dealing with health care fraud?

Mr. STERN. Well, let me answer it this way. We have already begun, I think, a very increased effort on health care fraud. That is what I am doing since last November, so a lot of the things that are indicated in the bill, such an effort to coordinate between HHS and the Attorney General—I am already doing that. The effort to allocate resources—we are doing that now.

There is a strong message in the health care fraud portion of this bill that says health care fraud shall be a criminal offense in and of itself without our having to use mail fraud or wire fraud or money laundering. So if I had my druthers, I would like to have a health care fraud criminal offense.

I think there are other provisions of the health care fraud bill, though, that are specifically tied to the kind of plan that comes out of this Congress, whether there are alliances, whether or not we are talking about statements that are used to buy people into a plan or to keep people out of a plan. I think our position has been, and I have to support it, that we ought to tailor what we do with the health care fraud portion to the actual bill that comes out of here.

Senator COHEN. What I am suggesting to you is, assuming there are no provisions for health care alliances—assuming that does stay in the bill, what I am suggesting to you is there are things that we can do today that we can later modify to take into account whether or not we have health care alliances, whether or not we have people buying into such plans, whether there are fraudulent statements made either by those who seek to get in or those who are providing the service; that we ought not to delay, to wait until we see the final shape of what the health care reform bill is going

to be before we pass legislation which can take effect more immediately.

It may be that we don't get a health care reform bill. Now, that is not my position. I hope we do, and there is a lot of movement on right now, but there is no guarantee. It could all fall apart some time during the course of the summer. So what I am suggesting is, given the magnitude of the problems, there are things that we could do today or could have done last year, and we have a chance in the crime bill itself dealing with the criminal statute, as such, and not defer any longer because we are losing millions of dollars—the estimates are \$275 million a day. That is a lot of money.

If you asked most taxpayers, saying we could take some action now and, like any other legislative proposal, expand on it later—if we get a better product coming out of the President's plan, so be it. That is what this body stands in practically constant session about, revising and amending, and it seems to me you can tailor provisions now that are open enough or expansive enough, or capable of being expanded, I should say, to take into account any kind of comprehensive health care reform.

Right now, there are debates taking place within the Democratic Party and within the Republican Party of, well, what should stay in and what goes—mandates on employers or employees; regional health alliances, no regional health alliances; voluntary, involuntary. We don't know, but in the meantime there are things that we could right now that we can all agree on that could be in effect that could help you in the Justice Department, the FBI, Health and Human Services, HCFA, the inspectors general, and others to combat fraud more effectively.

The only point I am making is we ought to do what we can do now, realizing we may have a more perfect product later. We could then amend this, not simply defer it waiting to have a comprehensive package that would be ideal. We don't always get the ideal coming out of here.

So I am not trying to in any way undercut the President's program. Indeed, I support most of the provisions in his proposal and our proposal; they are quite similar. But I just think that we should take what we can now and then work on it and build upon it later.

The reverse of this, of course, is that some people within the industry feel that you have adequate statutory authority right now, and this is simply a slam in the face of the industry; that it is really kind of overkill. I would like your response to that.

Mr. STERN. I think that they say that some people are concerned about why do you need an actual health care fraud crime when indeed we already have a fairly effective health care fraud enforcement effort using wire fraud, mail fraud, money laundering.

I think the simple answer is that we ought to send a strong message that health care fraud is a crime in and of itself, the same thing as we did with financial institution fraud where we made a Federal banking fraud crime. I think there should be a Federal health care fraud crime. People argue that maybe there is a technicality; I was being charged and convicted of mail fraud and it shouldn't have been used against me. I think it would be more use-

ful if we could have the direct Federal health care fraud crime itself.

Senator COHEN. Is there anything we can learn from the financial institutions prosecutions? As I recall, you have the reporting of fraudulent data. There is a requirement that they must report fraudulent information in the financial institutions. Is that something that we should also insist upon here?

Mr. STERN. Well, there are some things from the financial institution fraud area that are very useful and that we are trying to do even without the bill, but the bill provides some additional support. One is coordination. That was one of the major things we learned in financial institution fraud, is we had to bring everybody together, all of the agencies, as well as the law enforcement organizations. We are already doing that in the health care fraud area. The bills force us to do that, which is also good.

There is a specific provision in financial institution fraud that provides the civil U.S. attorneys with access to grand jury material so they can go civilly as well as criminally. There is a similar provision now in the health care fraud portion here which I think is a very good provision. So we have learned from financial institution fraud to try to do that here as well.

We are working now with the various carriers who pay these bills and we are working with the various agencies involved in health care fraud to find out what kind of reporting mechanism we ought to have. There is now a criminal referral form in the financial institution fraud area. I am not sure we are at that point yet in health care fraud. I have the FBI doing a lot of work on that specific problem right now.

Senator COHEN. Well, another answer to those who are critical of this effort would be that there are a number of cases, and one which has been brought to my attention in which a phony billing company was set up out in California to bill insurance companies nationwide for laboratory services that were not rendered. The owner of this particular company originally started out working for a legitimate outfit. He then smuggled home the doctors' tax identification numbers and the patients' medical insurance information, and then he set up a bogus billing service of his own.

At the time of his arrest, I think \$1.5 million in bogus claims had already been paid and there were many, many claim forms in the mail waiting to be processed. It is my understanding it took a good deal of time and resources to try to tie the money laundering statute in this one so the Federal prosecution and forfeiture could go forward. That is one of the problems we are trying to get at with this type of legislation.

Senator Biden mentioned his efforts in the field of organized crime. It was interesting. This morning, we had a hearing in the Governmental Affairs Permanent Subcommittee on Investigations and it was a remarkable hearing, actually. We had the Director of the FBI testifying, and beside him was a three-star general from Russia, and also the head of the police forces, as such, charged with international crime from Germany as well, but we had the Russian general who was there to coordinate efforts on international crime. Apparently, Eurasian international crime is spreading rather rapidly with the gangs, as such, or the organizations

starting up in Russia now spreading to all sorts of ties to organized families right here in the United States.

One of them happened to be in the field of health care fraud. Many of these Russian operations are now setting up shop here in the United States and engaging in the kind of thing I mentioned before about this fraudulent billing operation.

I serve as the ranking member on the Aging Committee, and the minority staff has been doing a lot of investigation in this field and we found the trends seem to be a great deal of abuse in the field of the nursing home industry and home health care. Is that something that your own investigators are finding?

Mr. STERN. Absolutely. In fact, this national group that I chair looking at the kinds of priorities we ought to be dealing with—home health care has been a very important one. Nursing homes has been a very important one.

Senator COHEN. The all-payer trust fund is something that I have in my own bill and I know it is in the President's bill. What can we do to minimize the notion that this is going to be a sort of a bounty system that we are setting up here?

Mr. STERN. First, of all, it is going to be jointly administered by the Inspector General at HHS and the Attorney General. I think the fact that two of us are doing it rather than one is a helpful check on each other. In addition, various State and other Federal agencies will be eligible to receive some of the funds from that account, and so they will be looking at what we do as well.

I think, also, we will be reporting yearly to the Congress under the bill as to what we have done with respect to the expenditures, which is another check on us. I think, finally, the most important check is that we are dealing with the Department of Justice bringing criminal prosecutions. We have our own guidelines that govern the cases we can bring, which we believe are the most effective and important check on what we do. I think the final result will be when you all look and see how we have done.

Senator COHEN. Well, now that my vice president has returned, I will try and shorten this up if I can.

The CHAIRMAN. You are the only guy I would take the job with.

Senator COHEN. In 1992, there was an article that appeared in Private Practice, and paraphrasing, I guess, as best I can, the charge is made that Congress looked on while Richard Kusserow, who was the Inspector General—Richard Kusserow's junk yard dogs used questionable tactics to meet prosecution and conviction quotas. That is a pretty strong statement and it obviously reflects a degree of animosity toward the Justice Department, Congress, and all those who were involved in this.

But I noticed that there were some 7,600 cases of exclusion from Medicare and Medicaid that were, in fact, prosecuted, as such. Out of that 7,600, only 25 were lost. With respect to civil monetary penalties, there were 900 cases, of which there were 25 lost. Again, it would seem to me to be a pretty strong record on behalf of enforcement.

If the numbers were the other way, if we had 7,600 cases and we lost 3,000 or 4,000, or even 1,000, I would say maybe there is something wrong here; we are being a bit over-aggressive. But that doesn't strike me as reflecting an arbitrary or in any way unfair

approach to trying to root out the kind of fraud that is involved here.

Just one final point, Mr. Chairman. In 1991, again, the staff of the Special Committee on Aging worked with your office in the Justice Department to investigate so-called DME, durable medical equipment, services, and again pointing out, as you did, Mr. Mangano, that we found in those particular cases that most of the DME suppliers were very, very legitimate. But there was a sudden flurry of fly-by-night operations, and it is astounding what they were able to get away with.

We had a case, for example, where—I won't forget this; I had the tangible evidence I was presenting during the hearing. We had a dry flotation mattress pad; it was a pad of pink foam. It was purchased by one DME telemarketer who paid \$28 for it. It was then sold to Medicare for \$1,100. That was the reimbursement that Medicare provided for that \$28 item because it was billed as a flotation mattress, and that is all it was.

We found out that within this particular type of industry, there are the so-called fly-by-night operators. They get involved in forum-shopping. They basically were going around to carriers, shopping. I can get a better deal maybe in Pennsylvania than I can get in Delaware or Massachusetts.

So we passed some legislation to tighten up on that, but is there anything that we need to do further? There is legislation that is, I think, pending now by Senators Pryor, Grassley, Simpson and others to start dealing with stricter standards for suppliers and to prohibit Medicare from issuing the multiple billing numbers. That is one of the real problems we had.

In fact, I applied for a number for myself up in Maine. Unfortunately, they got tipped off to what I was up to, but it is pretty easy for a carrier or a supplier to get multiple numbers. So they get stopped on one number and they apply another. Is there something that you would recommend in this field of durable medical equipment?

Mr. MANGANO. First, I would like to just thank you for all the work that you did on the Aging Committee because it was through that committee that we were able to bring this problem to the attention of the Congress, and you helped us solve a lot of that problem.

There are a number of things that the Medicare program has done which I think have been very good. Instead of every Medicare carrier paying bills right now, they have moved to consolidation to just 4 carriers.

Senator COHEN. They are down from 34 to 4.

Mr. MANGANO. That is correct, and so that means that there should be less deviation in the price from one carrier to the next. They have addressed the problem of carrier shopping by identifying the location of the beneficiary as to where the price should be set. So if the beneficiary is in Pennsylvania, it will be the rate that goes for Pennsylvania. There have been a number of other reforms in terms of gathering more information about the ownership of the durable medical equipment company itself. So those things have been good.

We continue to keep our eye on this area because even though we have solved a lot of the problems there, there continues to be an upcropping of new scams that are underway. Right now, we are investigating orthotic body jackets which—these are jackets that are very stiff that a person will wear from the waist up through the chest to protect them after a serious operation. We have found, and this may be hard to believe, but nursing homes which have bought orthotic jackets for their patients in their homes to keep them erect in chairs under the guise that they are no longer allowed to have restraints. Therefore, they will use these jackets, but these aren't the jackets that are supposed to be paid for under the Medicare program.

These might resemble things that you can remember your kids sitting in, in a high chair, with just a little piece of plastic with a strap over the top of it. The cost to the Medicare care program went up over 1,000 percent in 3 years on that until we began taking a look at it. Medicare has been taking a closer look at it and we are starting to bring those down. There are other examples—lymphedema pumps and oxygen services. When we looked oxygen, we found out that Medicare was paying twice as much as a number of other carriers.

We think that there is some additional work that could be done to improve uniform coverage decisions, and that is for Medicare to do a better job in terms of setting the reimbursement rate for specific pieces of durable medical equipment.

I want to do something that the IG's office is always negligent in doing, and that is I want to compliment the NAMES group, the National Association of Medical Equipment Suppliers. We have met with them a number of times. They have testified before you, and they have been out front with their organization trying to clean up some of the abuses that have existed.

Senator COHEN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you. Let me conclude by following up, Mr. Mangano, where Senator Cohen left off. You have both just listed a catalog of abuses that are illustrative of a number of the abuses that get us to that \$100 billion figure. What I am a little bit concerned about is under this legislation there is an expansion of your authority without a commensurate expansion of resources.

One of the things that I, as a general proposition, since I have been a Senator have most attempted to avoid—and what is, I think, reason for some of the cynicism with the public is we have tended to over-promise what we can deliver, we who sit up here, and administrations, Democrat and Republican.

Through the leadership of Senator Cohen and the work of you fellows and the agencies you represent, it has been called to the attention of the American people that there is a real problem. The fact of the matter is, 5 years ago, I don't think the American people were nearly as aware of the extent of the problem as they are now. Because of the work you have done, and the investigative reporters—the "20/20's" of the world—I don't know that "20/20" actually did it or "60 Minutes"—it is part of the parlance out there. People know that this fraud exists.

I think they are going to expect when we pass this legislation—"this" meaning health care and/or the separate piece in the crime

bill, or a combination of both—that we are really going to make some real progress. The truth of the matter is that it is not that you lack the ability even now to do more; it is that you lack the resources.

Now, I am concerned about whether you have adequate resources to enforce the laws throughout the entire industry, which is essentially what we are going to do now if we pass this legislation. I understand that your responsibilities are now to detect and prevent fraud and abuse in government programs, such as Medicare and Medicaid, which you have been talking about.

But I understand that you also, because of lack of resources, with government offices and their responsibility for that, have actually had to recently close some offices. Now, why did you have to close the offices, because there wasn't a problem? There was no work available for them?

Mr. MANGANO. Well, let me explain it in the following way. We ended up closing 9 offices, and there should be one more that will be closed. Over the last 3 years, we have been going through a budget reduction, reduction in number of staff. We have lost across the inspector general's office about 162 individuals. That would equate to about 11 percent of our office. Our number of investigators has decreased about 18 percent, although the percentage related to health care fraud has decreased about 11 percent, and the reason is quite simple. The budgets haven't kept up with what the need is.

We closed those offices because as we saw our resources shrinking, we had to decide where do we deploy those resources. We took a look at where the money was, where the problems were across the country, and felt that it was better to have investigators—

The CHAIRMAN. Please understand, I am not being critical of your decision.

Mr. MANGANO. I understand. I know you are not.

The CHAIRMAN. And you know better than I that you have a hell of a reputation as to where you should allocate those resources, but I am trying to make a broader point. If you had the resources, you wouldn't have closed any of those offices.

Mr. MANGANO. Well, that is correct.

The CHAIRMAN. As a matter of fact, you may even have opened other offices. I don't know about that. I don't want to put words in your mouth, but you wouldn't have closed the ones you closed.

Now, one of the things that Senator Cohen and I have observed in working this beat a little bit is that when it comes to inspectors general or agencies that provide for services to the public at large, given the choice of cutting the inspector general or the service, there is less squealing when you but the inspector general because you don't have the Medicare recipient saying, whoa, wait a minute, you cut me in some way, or you don't have the Medicaid recipient, or you don't have the hospital or the doctor or the provider. So you are the first to go—I shouldn't say first, but you are right at the top of the list.

The payback on this is enormous. We are going to hear in a moment from some State folks. I don't know precisely what they are going to say, but I would be surprised if they suggest that you don't more than justify the expenditures that are made by the taxpayers

for the taxpayers, which leads me to this last point, and I would like you to comment on all of this.

Historically, the FBI has investigated fraud in the private sector of our economy, rather than inspectors general. Now, as I understand the proposal, the inspectors general authority is being broadened to encompass private health care, the rationale being that we now are going to have a unitary system that, in fact, encompasses all Americans—that is the President's goal—and will incorporate private insurers in this operation as part of the program. I assume that is the rationale as to why the inspector general's role will be broadened. First of all, is that the premise?

Mr. MANGANO. That is exactly right.

The CHAIRMAN. Now, that is going to significantly increase your work. We have heard from the AMA and others that they don't like this idea. They kind of like the traditional way. The FBI deals with it and you all don't deal with it.

So can you discuss the propriety of giving plenary authority to HHS to investigate the entire industry, and then talk to me about resources? Then if you would conclude, Mr. Stern, if you are willing, by discussing the rationale of essentially moving it out of your department, Justice/FBI, into that authority being given to HHS and the inspector general.

First, you, Mr. Mangano.

Mr. MANGANO. Let me respond to a number of the points. You made the point about organizations paying for themselves. This inspector general's office returns about \$61 for every \$1 invested in it. If we were just to take the investigative side of our house, it is about 10 to 1 back, so we feel kind of proud of that.

With regard to expansion of our authorities, I think one of the reasons for the expansion of the inspector general's office at HHS having greater responsibility over the health care system really relates to a number of factors. One, we have been specializing in health care fraud ever since the Inspector General Act passed in 1976, so we have got a lot of years of experience in conducting these investigations.

Health care investigations in our department involve the same medical providers that insurance companies in the private sector are also dealing with. The kinds of fraud that we are dealing with are replicated throughout the system. Our view is that there ought to be at least one central administrative authority that could transcend jurisdictions and States in looking at the health care problem.

We do have some authorities that the FBI does not have right now, and that is the administrative sanctions. That would be the exclusions and the civil money penalties, so we can bring that authority to bear.

The CHAIRMAN. Now, explain what you mean by exclusions, again, for the record because I refrained from asking you about the exclusions.

Mr. MANGANO. Sure.

The CHAIRMAN. You have authority now as it relates to Medicare and Medicaid to say to a provider, whether it is a single doctor or a company, you are excluded from participating in any reimburse-

ment from the Federal Government from this point on, or for a period of time, right?

Mr. MANGANO. That is correct, and those exclusions are based on a provider being convicted of a criminal offense or abuse toward a patient that results in a conviction.

The CHAIRMAN. Right, OK, but the FBI does not have that authority?

Mr. MANGANO. Does not have that right now, but I don't want to mislead you. We work very close with the FBI and Jerry Stern at the Department of Justice, and in many cases the investigations—all of our investigations are going to be litigated through the Federal courts.

The CHAIRMAN. What is the total number of investigators you have now?

Mr. MANGANO. We have about—in our Office of Investigations, there are about 375 people. Of that, 222 are what we would call street agents. These would be investigators.

The CHAIRMAN. Now, what is the total budget you now oversee?

Mr. MANGANO. The budget of our office—

The CHAIRMAN. Excuse me. I misspoke.

Mr. MANGANO. The department?

The CHAIRMAN. Of the programs that dispense money, what are the total dollars that you look at protecting for the taxpayers?

Mr. MANGANO. For our department as a whole, it is over \$600 billion. Just if we looked at health care, Medicare right now is about \$158 billion, Medicaid is \$150 billion, and then we have a variety of programs in the Public Health Service that fit into that category over there, "Other State and Federal Programs." This would be community health centers, community mental health centers, family planning.

The CHAIRMAN. Just Medicare and Medicaid—

Mr. MANGANO. That is over \$300 billion.

The CHAIRMAN. Over \$300 billion, "b" as in "boy?"

Mr. MANGANO. Yes.

The CHAIRMAN. That is a lot of money, and you have—

Senator COHEN. "B" as in "Biden."

The CHAIRMAN. I wish it were "b" as in "Biden."

You have 222 people, and now your universe in universal health care is going to be in the trillion-dollar range.

Mr. MANGANO. Right. Well, let me comment further on that.

The CHAIRMAN. Yes, please.

Mr. MANGANO. I know, at least in the President's plan, there is an expectation that we would get more resources. We would get more investigators, we would get more auditors to look over the system. So we would not be talking about our office, with the number of investigators we currently have, taking on the entire system. We would get a commensurate increase in numbers of staff.

The last point I want to make on this is that with regard to the private sector, we have been working—we helped establish in 1985 the National Health Care Anti-Fraud Association. I know they are going to be testifying a little later, but ever since we helped them create that organization in 1985, we have been working to train them, to have joint training sessions. We share information. We talk about the kinds of cases that we are coming up with now and

help guide them into some areas that they may not be looking at as private insurance companies and, of course, they reciprocate by sharing that information back with us.

So I think we have got some pretty good experience across the health care field, and I suspect that that is why the President's plan had us play so prominent a role in the inspector general's office.

The CHAIRMAN. Well, I will end with this, but in the 1992 bill we added 50 investigators, which would get you up to around 275, roughly, but that was when we were talking about a much smaller piece of that pie. I think we will be kidding the American people if we do not significantly increase the resources commensurate with the size of the responsibility. I think you have got to be talking about 4 or 5 times the resources you have now to be able to deal with this.

I want to say for the record I do have some question about the authority vesting in your office, not because of capability, but quite frankly, and I will be really blunt about it, the ability to garner resources. I am in a much better position and the Senator from Maine is in a much better position for us to go to the public and our colleagues when we talk about increasing FBI agents—I am just being very blunt with you—and being able to say we are either raising your taxes, not lowering the deficit, because we are being a little more honest than our State counterparts are these days.

They want us to fight crime and we are telling them we are going to spend more money; that is how we are going to do it. We are laying off bureaucrats. We are going to hire these folks. This is where the money is coming from. I think there has got to be a little truth in legislating here.

Bluntly, it is easier for me to help get passed a piece of legislation on the floor that increases the number of FBI agents by 500 than it will be to increase the number of investigators in the inspector general's office by 500 or 700 because—and I shouldn't be saying all of this, but I am going to say it anyway because I need your help on this—interest groups can't take us on, quite bluntly, when we talk about the FBI.

Nobody has the wherewithal to come before us, whether it is the AMA or anybody else, and say, hey, we don't want any more FBI agents to investigate this. That one, I win walking away. On this one, you will find people confusing the hell out of the issue and you will be junkyard dogs, you know. I would challenge the AMA or any organization to send out a newsletter to their folks saying the FBI is junkyard dogs. They may be, but they aren't going to say it because they don't want to take on that junkyard dog—not a smart thing to do.

So I want to be blunt about it. I want a significant increase in the resources available for investigating fraud. I have no doubt that we are talking about paybacks for the taxpayers on the order of 10 or 30 or 40 to 1 in terms of dollars spent, but I really think it is going to make a difference how we do it.

I would yield to the Senator from Maine.

Senator COHEN. Can I just add one final comment before we go to the next panel? I was inquiring as to who was covering this particular hearing because I just want to say how important it has

been over the years to change people's attitudes. As a result of the hearings we held in the Aging Committee and now in this committee over the years, people watch and they see a change in their own sense of responsibility. I will give you one example of what has taken place over the last few years.

We had a man who received his bill from the hospital and he looked down and saw that there were such-and-such services rendered to him, and he said, that never happened; I wasn't even in the hospital that day. He ended up calling the local intermediary; I am not sure who the intermediary was at this time. He called, I think it was New Jersey first and they said, no, you have got to call Pennsylvania. He called Pennsylvania and they finally referred him out to Denver.

The response he got out in Denver was, what are you complaining about, what are you making so much trouble for; this is all being taken care of anyway; it is not costing you a penny. The whole attitude is one of kind of the socialization of crime, that as long as it is not coming out of your pocket, it is OK, don't raise a ruckus about it.

Well, this was one of those salt-of-the-earth types who raised a ruckus about it. He spent almost over \$1,000 of his own money to make sure he could come down to testify at an open hearing to say this is wrong, because the burden suddenly is handed to the individual consumer to then root out fraud in the system, and that is not the way it ought to work where that person has got to be the one bearing the sole responsibility.

As a result of that man's testimony, we saw the introduction of the 800 number and the consolidation of the various reporting centers, and so forth. So these hearings, whatever comes out of them, are helping to change the public attitude about what is taking place out in the world itself.

The CHAIRMAN. It is the only place I know, Senator, where you have all of the people involved in the industry wanting something to be done. Do you know who I hear the most from on this when I raise this issue? Doctors, not complaining; doctors want to see these other doctors nailed because they are the ones who carry the rap because all doctors get nailed. I am convinced the AMA would like to find every damn doctor who engages in this and lock them up, and have a big publicity day when they did it. So there are some really positive things happening here.

I just want to make it clear. I don't want to be a party to this unless we provide you the resources, and that is part of what I think is going to be the most difficult thing, is deciding how we are going to get that done.

Senator COHEN. One final point, if I can. Senator Biden is absolutely correct about the need to beef up the criminal investigation, but we ought not to diminish the significance of the civil side of things. One of the problems we have had is the Justice Department doesn't want to take on the burden of just prosecuting cases. They may find that the remedy here is too severe for the case, and therefore don't do anything. It is one of those all-or-nothing things.

That is why we have expanded the jurisdiction to have injunctions and other types of civil penalties so that we have a broad array of remedies so we don't either shut down an operation that

may be a rural hospital with no other facility in the region—shut it down over a violation where, in fact, something less onerous would be an appropriate remedy under the circumstances.

Even though you are right politically that we need more FBI investigators, we can't have it simply on the criminal side. We need both because this is going to be not only a criminal reform, but also on the civil side as well.

The CHAIRMAN. I agree. As I said, I haven't made up my mind. It is the doubt I have, it is my concern, as to how we get the resources. I am talking primarily about the investigators just to go out there and establish the case criminally or civilly.

You have been good witnesses. We appreciate the good work you have already done. We are going to have our hands full whether we just quote the crime bill with this in it or we pass an entire health care bill, which I would like to see happen. I look forward to working with you, and I suspect we will see each other in this forum again, so thank you very much for your cooperation.

Mr. STERN. Thank you, Mr. Chairman. Thank you, Senator Cohen.

The CHAIRMAN. Now, our next panel is made up of two distinguished State persons. Pamela Carter is the Attorney General for the State of Indiana and knows a little bit about this issue. She is also the Vice Chairperson of the National Association of Attorneys General Health Care Fraud Task Force. She was elected Attorney General in 1992. Welcome, General.

David Waterbury is the Director of the Washington State Medicaid Fraud Control Unit and is Legislative Committee Chairperson for the National Association of Medicaid Fraud Control Units.

I welcome you both. General, the floor is yours.

PANEL CONSISTING OF PAMELA CARTER, ATTORNEY GENERAL, STATE OF INDIANA, AND VICE CHAIRPERSON, HEALTH CARE TASK FORCE, NATIONAL ASSOCIATION OF ATTORNEYS GENERAL; AND DAVID W. WATERBURY, DIRECTOR, WASHINGTON STATE MEDICAID FRAUD CONTROL UNIT, AND CHAIRPERSON, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

STATEMENT OF PAMELA CARTER

Ms. CARTER. Thank you very much, and I am really pleased to be here, Chairman Biden and Senator Cohen. I am delighted to have the opportunity to testify today, and I think it is absolutely essential, and I commend you and this committee for having the States as a part of this dialogue.

As you well know, if you look back a few years when we had another major health care reform with Social Security, or even later with Medicare and Medicaid, later, and only after millions of dollars were lost, patients abused and neglected, did we begin to look at the issue of fraud, and I think it is absolutely essential to look at the issues fraud and abuse as we are looking at reforming the health care delivery system, on the one hand.

But I think even if we look back in the past when we had to put together very quickly the Medicaid fraud control units, we only looked at it in a very restricted way in an attempt to address a

problem that was magnified at that point because we had not looked broadly and contemplated through discourse, discussion and study the whole array of the potential for fraud and abuse.

So we want to come to you today to expand what we think is necessary at the State level in terms of looking at the State as a necessary component for law enforcement in the fraud and abuse area with regard to health care, and not restrict it to Medicaid. If we are beginning to look more broadly at the future for health care delivery reform, we would also like to make sure that the State's role and the necessity for State and Federal partnerships are addressed.

Obviously, the States will be playing a major role in designing and establishing a new health care delivery system, and State attorneys general will necessarily play a primary role in combatting fraud and abuse in that system. State law enforcement officials will be cops on the beat with respect to health care fraud. Happily, State law enforcement officials have developed substantial expertise during the past decade through the operation of some of our Medicaid fraud control units, most of which are located in Attorney Generals' offices. I believe that the most efficient and effective way to eliminate health care fraud is to build on this considerable anti-fraud expertise already available at the State level.

With these goals in mind, I would like to suggest five principles that will make health care fraud enforcement as efficient and effective as it can be. First, we would suggest that we have mandatory State health care fraud control units to deal not only with the present issues, but also anticipating health care reform to address the broader pie, but at the State and local level.

The CHAIRMAN. General, you mean that the Federal Government mandate that the States have such units?

Ms. CARTER. Absolutely.

If a State-based health care reform package which is similar to the administration's proposal or others is enacted, the Federal legislative framework for health care reform should require each State system to establish a health care fraud control unit with statewide authority to investigate and prosecute violations of Federal and State laws pertaining to health care fraud, in partnership with the Federal and local governments.

Let me talk really quickly about this partnership. In Indiana, we have been very successful in forging a seamless partnership with local, State and Federal officials with regard to health care fraud and abuse. As a result, sharing resources at a time when all of our resources are constricted, we have been able to get literally over \$1 million last year, and we are going to be able to double that this year, in combination with the U.S. attorney's office, the FBI, postal inspectors, local prosecutors and local police officers in conjunction with the investigators, auditors and prosecutors within our office in Indiana, and it is working well.

We have also cross-deputized one another, and we are on a roll and in a position to do more, and I would like to make sure that you understand that we don't want to go backwards. We also agree with you that we want to go forward so that we can hit the ground running, irrespective of what happens in the future.

The second principle and goal that we would like you to consider is the health care fraud unit should be separate from the State health agency or whatever kinds of alliances will be overseeing this process. As you are well aware, whenever you have the responsibility for overseeing a program, it may not be as effective in also supporting vigorous efforts to uncover fraud, waste and abuse in the program.

Additionally, the State health agency will be the entity responsible for establishing and regulating the health care delivery system in each State, including purchasers, providers and health plans, and it may become too involved with the entities it regulates to obtain objectivity.

It is also important that the health care fraud control unit in each State have statewide investigatory and prosecutorial authority. Presently, it exists in many States, but not all the States, and so we still have a fragmented approach to these issues.

If responsibility for health care fraud prosecution is divided among several geographically separate agencies, there may be, on the one hand, unnecessary and wasteful duplication of effort and, on the other hand, imperfect communication that allows fraud to fall through the cracks. In some cases, the office of the Attorney General is the only entity within the State with statewide prosecutorial authority, and almost all of the current Medicaid fraud control units are located in attorneys general offices.

Third, we would like the existing Medicaid fraud control units—

The CHAIRMAN. General, excuse me. You are a member of the Attorneys General Association.

Ms. CARTER. Yes.

The CHAIRMAN. Would you supply for the record today, tomorrow, the next day, or whenever, a list of those State attorneys general that do not have such authority?

Ms. CARTER. Yes, I would be delighted to.

Our existing Medicaid fraud control units should form the basis for the new health care fraud control units. We have the experience, we have multidisciplinary teams. We have already developed the partnerships and we are already effectively addressing these issues. The structure and expertise of the existing Medicaid fraud control units should provide the base for an expanded health care fraud unit which have the authority to prosecute fraud against any government or private third-party payer.

During the past 15 years, the Medicaid fraud control units have compiled an impressive record of convictions of Medicaid providers and have recovered millions of program dollars. Their activity has also had a deterrent effect on providers who might otherwise have engaged in fraud. They trained other law enforcement officials in health care fraud control and are well respected in the law enforcement community. These units are comprised of an integrated team of investigators, auditors and prosecutors who are able to effectively prosecute the wide variety of intricate financial crimes that comprise these types of fraud.

Even if the new health care delivery system eliminates some opportunities for fraud, many others will remain and those bent on defrauding the system will develop new ways of doing so. The ex-

pertise and training of the Medicaid fraud control units provide an invaluable basis for expanding these investigatory responsibilities.

Fourth, we too are going to urge for adequate funding. In order to ensure that the new system operates effectively, adequate funding must be provided for State law enforcement activities to combat fraud. Each dollar invested in State level antifraud activities will yield abundant savings and fraud prevention as well. The current Federal-State partnership in the Medicaid fraud control units should be maintained at at least the same contribution levels—90 percent Federal contribution for the first 3 years of the program and 75 percent Federal contribution from then on.

Last, we would also like to have State participation in the revolving fund. If the health care reform package includes supplemental funding of antifraud activities through a health care fraud revolving fund comprised of fines, penalties and forfeitures, the fund should also be available for reimbursement of State costs on Federal-State cooperative actions, and in appropriate cases States should participate in distributions from the fund on a proportionate basis.

This type of fund can provide an incentive for both State and Federal enforcers. However, it should be in addition to rather than instead of appropriate funding. The more successful an antifraud program is, the more dollars are saved by deterrence and not by direct prosecutions. In addition, even the best antifraud program can hit a slow period. A health care fraud revolving fund will be an excellent incentive, but an unreliable funding source.

Full, open communication and true partnership between State and Federal law enforcers is the best way to stop crooks and quacks from plundering the health care system and endangering patients' lives. Inclusion of the principles I have described in health care reform legislation will provide a more effective weapon in the fight against fraud.

I am delighted to answer any questions from you. Thank you very much.

[The prepared statement of Ms. Carter follows:]

PREPARED STATEMENT OF PAMELA FANNING CARTER

Good morning. I am Pamela Fanning Carter, Attorney General of Indiana and vice chairman of the National Association of Attorneys General Health Care Task Force. I am delighted to have an opportunity to speak about the importance of state and federal efforts to combat health care fraud, especially under a new health care delivery system.

The states are currently leading the fight against health care fraud and abuse. Through the Medicaid Fraud Control Units, state law enforcement officials have recovered millions from providers who sought to defraud the system, and have ensured that those people are barred from taking advantage of the system and endangering consumers in the future. In a new era of health care delivery and financing, the role of the States will be even more critical, both in ensuring that the cost of fraud and abuse is eliminated from the new system and in protecting consumers.

It has been said about several of the new health care reform proposals that they will virtually eliminate fraud through changes to the way health care is delivered and paid for. Although I hope that these predictions are true, I am afraid that persons who seek to defraud the system are ingenious and adaptable, and that fraud will simply continue in a different form. I therefore commend this Committee for examining the issue of health care fraud enforcement.

Many of the comprehensive health care reform proposals contain provisions designed to strengthen the hand of law enforcement in connection with health care fraud. As important as these new tools are, I believe that the most significant im-

provement in health care fraud enforcement will come from increased federal/state cooperation in investigation and prosecution of health care fraud. The states and the federal government must be full partners in the fight against fraud.

Much of the comprehensive health care reform legislation being considered by Congress, including the plan described by the Clinton Administration, contemplates a state-based system for regulating and delivering health care services. For example, the Clinton Administration has proposed a federal framework which will guarantee certain health care benefits and will prescribe certain quality standards. Within this framework, each state will be given the necessary flexibility to adopt a comprehensive system that will work best for the state. Each state will be responsible for designing and establishing purchasing alliances, certifying and monitoring providers and health plans that participate in the new system, including determination of appropriate capital standards to ensure plan solvency, and controlling health care costs.

Just as states will likely have the primary responsibility for designing and establishing a new health care delivery system, state attorneys general will necessarily play a primary role in combating fraud and abuse in that system. State law enforcement officials will be the "cops on the beat" with respect to health care fraud. Happily, state law enforcement officials have developed substantial expertise during the past decade through the operation of Medicaid Fraud Control Units, most of which are located in Attorney General offices. I believe that the most efficient and effective way to eliminate health care fraud is to build on this considerable anti-fraud expertise already available at the State level.

With these goals in mind, I would like to suggest some principles that will make health care fraud enforcement as efficient and effective as it can be.

MANDATORY STATE HEALTH CARE FRAUD CONTROL UNIT

If a state-based health care reform package similar to the Administration's proposal is enacted, federal legislation framework for health care reform should require each state system to establish a health care fraud control unit with statewide authority to investigate and prosecute violations of federal and state laws pertaining to health care fraud. As you know, Mr. Chairman, health care fraud not only endangers the lives of thousands of Americans, but also eat up ten cents of each dollar we spend on health care, or \$80 to \$100 billion each year. Increased health care fraud enforcement efforts will increase the cost savings necessary to help finance the new system by identifying program vulnerability and and suggesting solutions, as well as improving the quality of care for consumers served by the new system.

THE HEALTH CARE FRAUD UNIT SHOULD BE SEPARATE FROM THE STATE HEALTH AGENCY

The health care fraud control unit should be separate from the state health care agency which regulates the system and should be located in the office of the Attorney General. Because the state health agency will be the entity responsible for establishing and regulating the health care delivery system in each state, including purchasers, providers and health plans, it may become too involved with the entities it regulates to maintain objectivity. In addition, officials with the responsibility for overseeing a program may not support vigorous efforts to uncover fraud, waste and abuse in their program.

It is also important that the health care fraud control unit in each state have statewide investigatory and prosecutorial authority. If responsibility for health care fraud prosecution is divided among several geographically separate agencies, there may be, on the one hand, unnecessary and wasteful duplication of effort, and on the other hand, imperfect communication that allows fraud to fall through the cracks. In some cases, the office of the Attorney General is the only entity within the state with statewide prosecutorial authority, and almost all of the current Medicaid Fraud Control Units are located in Attorney General offices.

EXISTING MEDICAID FRAUD CONTROL UNITS SHOULD FORM THE BASIS FOR THE NEW HEALTH CARE FRAUD CONTROL UNIT

The structure and expertise of the existing Medicaid Fraud Control Units should provide the base for an expanded Health Care Fraud Unit which should have the authority to prosecute fraud against any government or private third-party payor. During the past 15 year, the Medicaid Fraud Control Units have compiled an impressive record of convictions of Medicaid provide and have recovered millions of program dollars. Their activity has also had a deterrent effect on providers who

might otherwise have engaged in fraud. They have trained other law enforcement officials in health care fraud control and are well respected in the law enforcement community. These units are comprised of an integrated team of investigators, auditors and prosecutors who are able to effectively prosecute the wide variety of intricate financial crimes that comprise Medicaid fraud.

Even if a new health care delivery system eliminates some opportunities for fraud, many others will remain, and those bent on defrauding the system will develop new ways of doing so. The expertise and training of the Medicaid Fraud Control Units provides an invaluable base for expanded investigatory responsibilities.

ADEQUATE FUNDING

In order to ensure that the new system operates effectively, adequate funding must be provided for state law enforcement activities to combat fraud. Each dollar invested in state anti-fraud activities will yield abundant savings in fraud prevention. The current federal/state partnership in the Medicaid Fraud Control Units should be maintained at least the same contribution levels—90 percent federal contribution for the first three years of the program, and 75 percent federal contribution from then on.

STATE PARTICIPATION IN A REVOLVING FUND

If the health care reform package includes supplemental funding of anti-fraud activities through a health care fraud revolving fund comprised of fines, penalties and forfeitures, the fund should be available for reimbursement of state costs on federal/state cooperative actions, and, in appropriate cases, states should participate in distributions from the fund on a proportionate basis. This type of fund can provide an incentive for both state and federal enforcers. However, it should be in addition to, rather than instead of, appropriated funding. The more successful an anti-fraud program is, the more dollars are saved by deterrence and not by direct prosecution. In addition, even the best anti-fraud program can hit a slow period. A health care fraud revolving fund will be an excellent incentive, but an unreliable funding source.

Full, open communication and true partnership between state and federal law enforcers is the best way to stop crooks and quacks from plundering the health care system and endangering patients' lives. Inclusion of the principles I have described in health care reform legislation will provide a more effective weapon in the fight against fraud.

I would be delighted to answer any questions from the members of the Subcommittee. Thank you.

The CHAIRMAN. Governor Bayh would be proud of the fact that you asked the Federal Government to fund this State function. Your reputation precedes you, General. You do one heck of a job, but as you know, because I have worked with you and the Attorneys General Association on crime legislation, I always find it fascinating that the National Association of Governors comes to Washington and they have always passed two resolutions. The first is balance the Federal budget, and the second is send us more money for State functions.

Then the Attorneys General come down and they pass—you are much nicer; you don't pass the balanced budget resolution. You are saying no unfunded mandates, but pay for mandates, as well as pay for things that are totally within the State. Now, we have got the State court judges coming and saying, by the way, the crime bill is going to cause more arrests because you are giving us 100,000 cops; why don't you pay for State court judges?

One of these days, the State governors and the legislators are going to have to say, hey, we are going to raise your State taxes at home to pay for this stuff and we are not going to tell the Federal guys to raise the taxes. On the forfeiture end, I think you are absolutely right, but I want to talk to you a little bit later about us funding State fraud units in attorneys general offices.

Ms. CARTER. That is fine.

The CHAIRMAN. But I am glad to see that tradition has been maintained.

Now, Mr. Waterbury, I am sure you have some things you want us to pay for. We want to thank you very much for being here and for all you have done. I shouldn't be facetious. That was a bad attempt at a joke.

The floor is yours, Mr. Waterbury.

STATEMENT OF DAVID W. WATERBURY

Mr. WATERBURY. Thank you. Good afternoon. My name is David W. Waterbury. I am an Assistant Attorney General and Director of the Medicaid fraud unit in Washington State. I am a career prosecutor. I have done this job for 11 years. Health care provider fraud is a day-in and day-out activity lately, 7 days a week, in my life, especially for this last year.

I would just like to say something about funding for a moment before I go on. The funding that Attorney General Carter is referring to, both now and in the future, is a State-Federal cooperative effort. As you know, the Medicaid program is approximately 50 percent Federal funding and it is administered by the States. Attorney General Carter's budget in the State for Indiana contains a line item for Medicaid fraud control units. It is paid for by the State legislature.

The CHAIRMAN. But not 50 percent.

Mr. WATERBURY. That is true. It is 75 percent Federal funding and 25 percent State.

The CHAIRMAN. And you recall the request was for 90-10.

Mr. WATERBURY. That is what the transition start-up fees are for the establishment of any unit and that is for a 3-year purpose, but I just wanted to make sure that that was clear on the record.

We hope we do a good job for you with that funding in the Medicaid fraud control units in the attorneys general office, and we work very hard. We have been in existence for 15 years. There are 42 Medicaid fraud control units now. We are responsible for about 7,000 health care fraud and patient abuse prosecutions and convictions in the last 15 years, and the sanctions and the medical licenses that were pulled accordingly as a result of those. On a day-in and year-out basis, the Medicaid fraud control units are responsible for the majority of the health care fraud convictions in the United States of America.

What you saw before you a little bit earlier today is a new and resurrected interest from a Federal standpoint on health care fraud, making it a national priority. People who have done this work in the past are trying to reorganize and do the best job they can. We have been on point on this very specific mission for a number of years. Let me just give you as quickly as I can—

The CHAIRMAN. You, the State of Washington?

Mr. WATERBURY. All State Medicaid fraud control units.

The CHAIRMAN. Wrong.

Mr. WATERBURY. Many of the State fraud control units.

The CHAIRMAN. Right.

Mr. WATERBURY. I would be glad to talk to you about any that you don't think are doing as good a job.

The CHAIRMAN. No, no. I think they are by and large doing a good job, and some are doing a phenomenal job.

Mr. WATERBURY. There are a couple of reasons, I think, why we do a good job, and in looking at Federal legislation and things that you can do to help us in this enforcement area in the future, I would like you to draw on some of our successes or reasons why I think we did a good job, or have done a good job.

First is the multi-disciplinary approach referred to by Attorney General Carter. We are not a traditional prosecutor's office. Our offices are made up of in-house prosecutors, usually; legal advice available on a daily basis, and investigators and auditors. I personally believe this is the only way to effectively and efficiently do white collar crimes. It is patterned after the organized crime strike forces years ago. It has worked very, very well in this particular area.

Our mission statement is very narrow. We don't get pulled off for auto accident cases or this or that at any given point. You have defined our mission and we try to stay on that mission, and I think to the extent that you have defined it narrowly, it has been brilliant because we have dedicated and been able to train ourselves and prepare ourselves in this area, not wander around doing other things, and our expertise and our effectiveness is probably beholden to that kind of definition. I ask you to consider that when you are looking at funding these other sources and other people to do this kind of work. I think that is important.

We are supposed to work very closely with the health care payers. We are required to have MOU's with our Medicaid programs.

The CHAIRMAN. Explain MOU's for the record.

Mr. WATERBURY. Memorandums of understanding between the people that administer and run the program and the people that do the health care fraud investigations and prosecutions. They are required to refer cases to us of suspected fraud based upon their audits and findings. We are required to report our findings back to them so they can exclude providers that are prosecuted and convicted.

In the best-case scenario, this results in a partnership where the Medicaid director in my State, for example, will sit down and ask me what do you think of these new rules; can you enforce these if somebody attempts to violate these, or can you send me your findings that your investigators make so that we can administer this program better.

In the back of every file that we close in my office, there is a one-page—we call it the David Waterbury bureaucratic piece of paper. Please fill out this form. How could you keep this from happening again? Can the rule be changed? Can the program be changed? How did this happen? It is a two-part form. We send it to the Medicaid program. They tear off the bottom and send back the results, and we track those the same way as we track every case in the unit.

If we pay our way, we pay our way with that one piece of paper, frankly, as much as we do with the criminals that we convict and hopefully deter others. But we make important contributions in running the programs better, we hope, and it pays dividends as well.

The other thing that I think the units do really well is adapt to changes within the programs. I have asked to address managed care-related fraud issues, and I will do that as quickly as possible. Hopefully, this is an example of adapting. There are some experiences in the States with managed care-related programs that have been experimental in nature in the Medicare program.

The primary greenhouse or hot house of managed care has been the Arizona situation, the Access program. I am sure you know the history of the Access program in Arizona. It was one of the last Medicaid States to come on line. It is not called Medicaid there. It is called Access, and it is basically a huge managed care, some portions managed competition, program. My comments are based on the Arizona experience.

Our association drafted what we call a white paper to the President's task force on problems in the managed care area and it is attached to my testimony. I don't have time to go through all of it, but if you are looking at new criminal statutes to attack problems of fraud inside managed care, please review it.

The problem we see, of course, is underutilization in managed care. In the old fee-for-service system, your incentive is to overutilize. The ultimate overutilization is a phantom visit. In other words, you are able to get somebody to pay you for something that doesn't even happen, or if the person is there, now you charge for an injection that never occurred. Again, it is a fee for a service that doesn't occur; it is overutilization.

Once you start paying somebody \$300 a month, or a group of entrepreneurs or professionals to take care of somebody for \$300 a month, the incentive is not to provide as many services during the course of that month.

The CHAIRMAN. Does that diminish the fraud? Is that the bottom line?

Mr. WATERBURY. That is an interesting question. It changes the fraud. What you have is overutilization in a fee-for-service setting. Once you cap the payments, you have what I guess I would refer to as entrepreneurial fraud. This would be illegal subcontractor relationships between primary contractors who deal with big alliances or whatever to get these contractors to take care of people, people they pay as runners to go out and sign up a population because they get paid by body count.

You have incentives. For example, you pay your surgical department at a hospital a budget of about \$100,000 a month and you get to keep the difference if you don't spend it all within the budgeted target. What does that do to medical judgment within that setting and how do you make decisions? Is that the appropriate incentive to set up in that setting?

The CHAIRMAN. I don't want to be having an aneurism operation in that hospital. I can tell you that.

Mr. WATERBURY. I would not think so. Two days ago, I was in my office having a team meeting with one of my investigators who is investigating on the streets in the Puget Sound area a Medicaid provider, and this Medicaid provider had hired what we call a runner to go out to particular ethnic groups at a housing project and pick up their identification cards for Medicaid.

This went on for about 1½ years. He used those identification cards to bill for services that never occurred, and to also write out script for drugs that were never received. The drugs were then billed by the pharmacies, collected and resold to pharmacies. That is the case we are investigating.

In the last 6 months, this doctor under investigation has signed up for what is called Healthy Options in the State of Washington, which is a managed care program inside the Medicaid program, an experiment in the State of Washington. This doctor's incentives have changed. My investigator told me on debriefing the informant the following. This doesn't go on anymore. He doesn't send me out to the projects to pick up the Medicaid cards anymore. Now, he doesn't want to see people. I am instructed to go back and tell the people in the projects that the doctor is not available, that he is fully booked, and that they should go to a community center, and the doctor will help arrange for transportation for anywhere but to his office.

This medical practitioner has also been unavailable to see his patients for as long as the last 3 weeks while his office was under surveillance while he is receiving capitated payments for the month. I guess he is going to make it up in the last week. These are serious concerns.

I guess you could ask me a question whether people that are so inclined to commit fraud will change their stripes under a new payment system. I brought this along to share with you because apparently it is part of my life this week, and this adaption will occur fairly quickly and we are trying to learn about this so that we can help you help us.

Just very quickly, what can you do to help us? I think Medicaid fraud control units need broader jurisdiction. I believe that we should monitor all Federal programs at the State level. In my case-load, we quite often do Medicare prosecutions in State court, whereas CHAMPUS prosecutions and private insurance cases in conjunction with Medicaid fraud cases.

We are in a better position to stand in front of a judge and get a defendant fully punished and fairly punished for the full breadth of their fraudulent activity and to return monies to other Federal programs, especially Medicare. I am poaching on the regulations that control the funding in my office by doing that. I am candidly admitting that to you.

We are also proud of our work in the area of patient abuse investigations, which I think you have heard about before. We are the only agency in the country that really has that responsibility. Right now when I send an investigator to nursing home, that investigator drives by five board-and-care facilities where we have received complaints, but can't do anything about it. They can't stop in the car with the Federal money in the gas tank under the Federal regulations that we are running to go to that nursing home. Nursing homes are covered. Board-and-care and alternative residential facilities and home health care settings are not covered.

We are requesting that we change our underlying legislation to allow us to look at patient abuse situations in any setting where there are Federal funds received, and I don't think that that is a radical departure from what the intent of our original legislation

was 15 years ago. Fifteen years ago when this was put together and Congressman Pepper said, while you have your investigators out there doing fraud in nursing homes and investigating, check on this patient abuse situation while you are there because we don't think anybody is looking, nursing homes were the only game on the block, so to speak, at that time, 15 years ago. Now, there is a whole new generation, an evolution, of alternative settings. We are asking that we be allowed to look into those settings as well, expanding the Federal nexus and funding.

Our association has a draft proposal which would change Medicaid fraud control units to the health care fraud control units that Attorney General Carter spoke of. That is available and it is an attachment to the packet.

I know I am beyond my time. One last thing. Also, an attachment referred to in the testimony is just a 2-page list entitled "Ways to Deter Fraud in Managed Care." I lifted this the other day from Professor Bucy's article in a brand new Villanova Law Review article that she sent me. It is definitely well thought out. I think there are 10 things listed. They include ways that she thinks we could make the relationships in a managed care setting tight enough so that fraud could be adequately forced, and that is included as an attachment with a citation of the law review article. To the extent that we do end up with a health care reform package that relies on managed care, this should be given some thought.

Without asking me to answer the question you asked the Federal authorities, whether you should go forward with health care anti-fraud legislation in the meantime, I wholeheartedly support that you go forward with legislation in the meantime and that you include the States as part of it.

Thank you. If you have any questions, I would be glad to answer them.

[Mr. Waterbury submitted the following materials:]

PREPARED STATEMENT OF DAVID W. WATERBURY

Mr. Chairman, Members of the Committee: As Chair of the National Association of Medicaid Fraud Control Units' Legislative Committee and Director of the Washington State Medicaid Fraud Control Unit, I am very pleased to appear before you today to discuss the role of the states in investigating and prosecuting health care fraud and patient abuse.

BACKGROUND

The Medicaid program, which was established to provide health care to indigent patients, has seen its enrollment explode. Nationwide, the Health Care Financing Administration is expected to spend more than \$140 billion in fiscal year 1993 to sustain the Medicaid Program. State expenditures for Medicaid have doubled in the past five years and in some urban areas, such as Baltimore and New York, it is not uncommon for one-fourth of the population to rely on the Medicaid program for their basic health needs. Even though Medicaid is generally funded 50 percent by federal money, several states now spend between 15 to 20 percent of their general budget to sustain the program. Medicaid also continues to finance almost half of the total costs for nursing homes, spending 45 percent of the \$53 billion that was spent on institutionalized care in 1990.

And as our population ages, enrollment in the Medicare program has similarly increased, costing the federal government billions of dollars each year. In Florida, a state in which the elderly population is higher than the national average, there are over 2.4 million people enrolled in the Medicare program. Medicare spent an average of \$3,375 per enrollee in Florida last year, for a total expenditure of \$8.1 billion dollars. In Maryland, a state nearer to national averages, over \$2.3 billion dollars

was spent last year on behalf of 553,000 Medicare enrollees, for an average cost of \$4,159 per enrollee.

By 1995, this nation is expected to spend \$1 trillion on health care or 15 percent of our gross national product. Given these figures, it is not surprising that our health care delivery system has proven ripe for fraudulent activity.

The General Accounting Office (GAO) recently estimated that fraud and abuse accounts for 10 percent of health care costs, currently exceeding \$800 billion, and while there may not be a way to establish a precise figure, we are certainly talking about many hundreds of millions of dollars of fraud and abuse in the Medicaid program alone. GAO stated further in testimony before the House Subcommittee on Crime and Criminal Justice on February 4, 1993 that only a fraction of health care fraud and abuse is identified and prosecuted. GAO acknowledged that without adequate resources, effective investigation and prosecution of health care fraud is not possible.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid Program, a period of unprecedented white collar "wilding" in which wave after wave of multimillion dollar frauds have swept through nursing homes and hospitals, to clinics and pharmacies, durable medical equipment (DME), and labs, and more recently, home health care. Although we do the best we can to put an end to program vulnerabilities, we still have profiteers who search and succeed in finding the next great loophole in the Medicaid system.

STATE INITIATIVES

While the investigation and prosecution of health care fraud has only recently become a top national law enforcement priority, the states have been combating health care fraud for the past 15 years.

In 1977, Congress enacted legislation, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142 which established the state Medicaid Fraud Control Unit Program. The objective of this legislation was to strengthen the capability of the government to detect, prosecute and punish health care fraud. In addition to investigating and prosecuting providers who defraud the Medicaid program, the mandate to MFCUs specifically includes the authority to prosecute the abuse or neglect of patients in all residential health care facilities which are Medicaid providers. The Units are staffed by professional teams of attorneys, investigators and auditors specifically trained in the complex litigation aspects of health care fraud. The Units are required to be separate and distinct from the state Medicaid programs and are usually located in the state Attorney General's office, although some Units are located in other state agencies with law enforcement or auditing responsibilities such as the state police or the Auditor General's office.

States which establish Units receive 90 percent of their operating costs from the federal government for the first three years—the so-called "start up" period. After that, the Units are reimbursed at 75 percent. This federal grant money is transferred from the Medicaid trust fund to the HHS Office of Inspector General, which administers the grants to the states.

Since the inception of this pioneering program, 41 federally certified state units have successfully prosecuted over 7,000 corrupt medical providers and vendors and elder abusers—convictions that would not have occurred without this vital piece of legislation. These 41 Units police 92 percent of the nation's Medicaid expenditures with combined staff of approximately 1,150 and a total federal budget of \$62 million. This amount represents a small fraction of the total Medicaid budget that the Units are responsible for policing. Missouri's MFCU was certified in January of this year and became the 42nd MFCU.

Last year's Omnibus Budget Reconciliation Act now requires all states to have a Medicaid Fraud Control Unit, unless a state can demonstrate that there is a minimum amount of Medicaid fraud and that beneficiaries will be protected from abuse and/or neglect without an MFCU. When this provision of OBRA becomes effective in January, 1995, we can look forward to all 50 states having MFCUs which will make the fight against Medicaid provider fraud truly nationwide.

In addition to the criminal consequences of MFCU cases (repayment of restitution, overpayments, state exclusions, incarceration, and often the loss of professional licenses) the criminal convictions of the Units become the basis for further federal actions. These federal actions are reported to you by the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) and include the underlying state convictions, forfeitures, federal program exclusions, and civil monetary penalties. In fact, the majority of health care fraud convictions, penalties, and exclusions reported to you are based upon MFCU convictions. The MFCUs are the

most efficient and effective law enforcement agencies in the battle against health care fraud and patient abuse.

While this remarkable success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the Units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect. Congress enacted P.L. 95-142, not only because of the widespread evidence of fraud in the Medicaid Program, but also because of the horrendous tales of nursing home patient abuse and resident victimization—and the Units are justly proud of their record in protecting the frail and vulnerable institutionalized elderly.

FRAUD INVESTIGATIONS

In the past decade, we have seen a rapid increase both in the number of fraudulent schemes and the degree of sophistication with which they are committed. Although the typical fraud schemes such as billing for services never rendered, double billing, misrepresenting the nature of services provided, providing unnecessary services, false cost reports and kickbacks still regularly occur, new and often innovative methods of thievery are now appearing.

Medicaid fraud cases run the gamut from a solo practitioner who submits claims for services never rendered to large institutions which exaggerate the level of care provided to their patients and then alters patient records in order to conceal that lack of care. MFCUs have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

Medicaid fraud is a pervasive and well-documented problem throughout the United States. For example:

- In California, disreputable providers of incontinence supplies obtained eligibility information from Medical beneficiaries and billed the program hundreds of million of dollars for beneficiaries who were not incontinent or for supplies that were never ordered or delivered.
- The Wisconsin MFCU uncovered an extensive pattern of fraud involving dozens of firms in the medical transportation industry. Typical scams included: padded mileage; billing for phantom second attendants; charging for trips either not provided or not prescribed; forging physicians' prescriptions; and paying kickbacks to riders.
- In Massachusetts, the Medicaid Fraud Control Unit recently achieved the largest civil recovery in its 14-year history when a Boston hospital and rehabilitation center agreed to an unprecedented \$12 million settlement.
- A Virginia pharmacist, who pleaded guilty to 6 felony counts of Medicaid fraud and grand larceny from Blue Cross/Blue Shield, was sentenced to 90 years in the state penitentiary. The 90-year sentence was suspended on condition that he serve 12 months in jail, make restitution of \$270,000, surrender his pharmacy license, and agree to withdraw as a Medicaid provider for life. The pharmacist had billed for expensive medications that were not prescribed by a physician and not received by patients. This ripoff, the defendant said, was "just too easy" and all he had to do was "push a few keys on his computer."
- In Tennessee, a Nashville radiologist pleaded guilty to obtaining money under false pretenses and was ordered to pay \$210,000 in restitution. The physician, a native of West Africa who was in the United States illegally at the time, had billed for CAT scans he never performed.
- Nursing home operators in Pennsylvania and North Carolina have been convicted of charging personal luxury items like jewelry, swimming pools, and the family nanny to Medicaid cost reports.
- Physicians who are nothing more than drug dealers with prescription pads have been found in Philadelphia, Baltimore, Detroit and elsewhere, providing Medicaid recipients with addictive and medically unnecessary tranquilizers, painkillers, cough suppressants, and diet control pills.
- In Jacksonville, Florida, a psychiatrist who spent an average of less than 5 minutes with each patient, billed Medicaid for 45-50 minute individual psychotherapy sessions.
- In New York, a home health care provider and four company officials were convicted of cheating Medicaid out of \$4.6 million and of recklessly sending out so-called nurses who were not licensed and often had no training whatsoever into the homes of critically ill-care dependent patients in the largest fraud in the home health industry.

Perhaps even more important than any specific prosecution or recovery, however, is the fact that the Units have demonstrably deterred the loss of many more hundreds of millions of dollars in Medicaid overpayments. We have often witnessed a pattern of skyrocketing Medicaid expenditures followed by a sudden, sharp dollar decline in the wake of a Unit's investigation of a particular provider group.

PATIENT ABUSE AND NEGLECT

I would also like briefly to share with you some of our findings in the area of patient abuse. Patient abuse can be classified into several categories. For example, providing inadequate medical or custodial care or creating other health care risks may constitute patient neglect. Physical abuse includes acts of violence such as slapping, kicking, hitting or punching a patient and sexual abuse. Financial abuse includes the misappropriation of patients' personal funds such as commingling patient and facility funds or using patient funds to pay for facility operations.

Scores of investigations and years of cumulative experience have made it clear that the abuse, neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. Our national association, in collaboration with the National Association of Attorneys General (NAAG), has therefore promulgated a model patient abuse statute—already adopted in several states—that would not only provide the necessary prosecutorial tools and enhanced penal sanctions for combating this type of shocking misconduct, but would also serve as a powerful deterrent to potential patient abusers.

Let me highlight a few examples of the Units' work in this area:

- A Baltimore doctor was sentenced to two years in jail for criminal neglect of his nursing home patients. As the facility owner and medical director, this physician failed to provide even the most basic medical care to his patients and refused to allow other doctors into the home to do so, leaving many of the residents with malnutrition, dehydration, and untreated bed sores.
- A New York physician was criminally prosecuted for willful neglect and reckless endangerment of a nursing home patient in his care. He mistook a peritoneal dialysis catheter in the patient's abdomen for a feeding tube, and ordered that she be fed through the catheter. When this error was discovered two days later, he made a conscious decision to do nothing to help the patient despite expert advice that the patient required hospitalization for treatment. Finally, ten hours later, the physician agreed to transfer the patient to the nearby hospital for care.
- In Arizona, a residential care home owner was sentenced to serve 21 years—the longest sentence for elder abuse in the state's history—for neglecting and abusing his aged patients. To induce families to place their relatives in his facility, the defendant had lied to them about his licensure status.
- Four nursing home officials in Philadelphia were charged with involuntary manslaughter in the death of two nursing home residents who died from massive and infected bed sores.
- Beverly Enterprises, Inc., the largest nursing home chain in the nation, agreed to pay Oregon \$600,000 and to improve care at their 17 facilities in the state, after an MFCU investigation of a Beverly home found evidence of inadequate staff training and supervision, and other conditions constituting an immediate threat to resident health and safety.
- The third largest nursing home corporation in Texas, (the ninth largest in the nation), four corporate officers, and four employees were indicted on charges related to the death of two facility residents. One patient allegedly died from neglect, and the other, who suffered from senile dementia, was allowed to wander from the nursing home, became lost, and died of exposure.

And beyond these egregious cases of corporate and management neglect, the Units have also uncovered hundreds of incidents of individual nurses, aides, and orderlies raping, sodomizing, beating, kicking, and force-feeding the helpless, often incompetent patients in their charge.

JOINT INVESTIGATIONS

Medicaid cases often have a significant Medicare or private insurance component. The Units regularly conduct joint investigations with a wide range of state and federal criminal justice agencies such as the FBI, OIG, Postal Service, DEA, DOJ, and the various United States Attorneys, as well as various state licensing and regulatory bodies. Of course, the Units also work cooperatively with each other and share information on multi-state investigations.

An outstanding example of a federal/state partnership is the case of *United States v. National Health Laboratories, Inc.* (NHL). National Health Laboratories, Inc., headquartered in La Jolla, California, is one of the largest medical laboratories in the country.

NHL's national marketing and billing scheme began in 1987 when the laboratory added an HDL—cholesterol test to every blood chemistry panel test ordered by a physician. The blood chemistry panel, also known as a "SMAC" (Sequential Multi-Analysis Computer), is a series of up to 42 blood tests performed on a single machine, and is widely used by physicians for a variety of diagnostic and monitoring purposes. Because the marginal cost of performing additional tests on SMAC is very low, Medicaid, Medicare, and insurance carriers pay a flat fee for tests performed on the SMAC requiring only that the ordering physician believe that at least one of the tests is necessary for the care of their patient.

NHL conducted business with 33 state Medicaid programs where there are MFCUs. These 33 MFCUs supplied the federal grand jury investigation with witnesses and data demonstrating the true national character of the fraud scheme. At the conclusion of the investigation, the 33 MFCUs were instrumental in formulating a settlement which resulted in guilty pleas by NHL and its president and chief operating officer to Champus and Medicaid fraud. The guilty pleas and sentencing guaranteed a \$100 million federal settlement and a \$10.4 million settlement to the 33 state Medicaid programs and the removal and exclusion of the corporation's executive officers from future Medicaid and Medicare program billings. With the successful conclusion of this case we can expect to uncover more multi-state fraud schemes in the future.

FRAUD IN MANAGED CARE PROGRAMS

Both the Medicaid and Medicare programs have experimented with managed care. In some states, managed care has been in existence since the early 1980's. Recently, more states are requiring greater numbers of their Medicaid population to participate in their managed care programs.

Proponents of the managed care system believe that it is the best method for providing low cost high quality health care to more people. Managed care is not only supposed to save money but it is also designed to cut down on the amount of paperwork. While many observers point out that the very nature of managed care prevents fraud, the experience of the fraud control units, the Arizona Unit in particular, the Medicare program and the private insurance industry, reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans. Rather, fraud simply takes different forms, in response to the way the program is structured.

While the traditional Medicaid provider fraud investigation focuses on overutilization of services and fraudulent billing and seeks as the ultimate aim accountability for claimed services in managed care investigations, the evil more likely lies in the underutilization of services. Unlike the typical Medicaid provider fraud case, the human cost in terms of reduced access to quality care may be tremendous.

In Maryland, for example, the Medicaid Program has initiated a limited managed care approach which pays physicians a minimal monthly fee for each patient for whom they assume primary responsibility. The Maryland MFCU recently prosecuted a physician who "treated" between 90 to 100 patients a day, recording for each patient the identical blood pressure and pulse rate, and using a rubber stamp to diagnose the same ailment for most. Although he then billed Medicaid as if he rendered a "comprehensive" medical examination for each patient, the sad truth was that his patients received no medical care and, in several cases, suffered from conditions that worsened due to his neglect. When questioned by MFCU staff, he was unable to provide the name of a single patient for whom he allegedly provided care. The physician was convicted of felony Medicaid fraud. He was ordered to repay the Medicaid Program \$93,500, given a suspended sentence, permanently barred from the Medicaid program and his license to practice medicine has been suspended.

Many of the health care reform bills that have been recently introduced in Congress, by members of both parties, rely on a managed care system to reduce costs, curtail fraud and provide universal coverage. For those who doubt that fraud will occur in any managed care program, I would like to recommend the Association's report; "Health Care Provider Fraud: The State Medicaid Fraud Control Unit Experience, A Report Prepared for the President's Task Force on National Health Care Reform." This report, which is attached, concludes that no health care plan is immune from fraud, but rather that fraud will simply take different forms in response to the way the program is structured. The state MFCUs have documented several types of criminal activity in managed care plans including: fraudulent subcontracts;

fraudulent related party transactions, excessive salaries and fees to participating entrepreneurs; bribery, tax evasion, kickbacks, rebates and other illegal economic arrangements; and fraud in the administration of the program. Quality of care problems occur more frequently in managed care programs than in the traditional fee-for-service payment program. These problems include underutilization of necessary services, falsification or misrepresentation of professional credentials by providers and the use of unlicensed providers. State Medicaid Fraud Control Units should be consulted when the federal or state governments develop new health care programs.

In a recent Villanova law Review article, "Health Care Reform and Fraud by Health Care Providers," Professor Pamela Bucy concludes that health care provider fraud will exist in any health care system, including a managed care system. The types of fraud include: submission of false cost data in order to obtain higher capitation rates; enrollment of fictitious members; underprovision of necessary services while misrepresenting that all needed services have been provided; and paying kickbacks for referrals of healthy patients. In her article, Professor Bucy lists ten steps that should be taken to deter and detect fraud in a managed care system. I have attached a copy of those recommendations for the record. Unscrupulous providers will find new and innovative ways to criminally profit at the expense of patients and health care payers. A program for the detection and prosecution of those who will prey on any health care delivery system should be included in the design of any new delivery system.

Increasingly, the state MFCUs have come to be viewed as leaders in the detection and prosecution of fraud in the health care industry. They are responsible for the majority of health care fraud prosecutions in the United States. The Units are well respected within the law enforcement community, are equipped with highly trained staff, and have over 15 years of experience in investigating and prosecuting these complex cases.

The Medicaid Fraud Control Units should be used as a model for future state-based health care provider fraud control units. Recently, the NAAG Health Care Task Force, chaired by Massachusetts Attorney General Scott Harshbarger, unanimously endorsed a legislative proposal drafted by the National Association of Medicaid Fraud Control Units that would expand the jurisdiction of the state Medicaid Fraud Control Units (MFCUs) and allow them to investigate and prosecute fraud in other federally-funded or mandated programs. A copy of this proposal is attached. According to this proposal, the Units would continue to be the primary state component of a national health care fraud strategy. The proposed statute would retain the essential elements of the MFCUs. These Units, at the very least, would be responsible for policing the Medicaid portion of any state program and, at most, for policing all federally-funded or mandated health care programs in the state. The Fraud Unit would continue to be responsible for patient abuse investigations and prosecutions with additional authority to pursue patient abuse in alternative residential facilities and in home health care. To accomplish program integrity, oversight should continue with the HHS Office of Inspector General.

In any Congressional discussion which would substantially expand state enforcement responsibilities, the states would expect a further funding commitment. At the very least, the current federal and state funding partnership that contributes to the success of this program should be maintained, at the same contribution levels, of 90 percent federal funding for the first three years of this increased responsibility to 75 percent thereafter.

Enhanced criminal statutes should be drafted to address program vulnerabilities in any health care delivery system that evolves from health care reform proposals. The National Association of Medicaid Fraud Control Units is currently drafting a model criminal statute that would assist the states with supplementing existing statutes if the health care delivery system moves away from fee for service to managed care.

NAMFCU would like to recommend that a state/federal clearinghouse be established which would assist with the coordination of health care fraud investigations. This would accomplish multi-agency coordination between state and federal law enforcement efforts. Regionally-based clearinghouses should be established in each state with representatives from state and federal health care law enforcement agencies. In order to create a meaningful federal/state partnership, all federal restrictions on information sharing should be reviewed and amended to effect the interchange of information between MFCUs and federal authorities. I would like to suggest that Congress consider establishing a demonstration project that would develop guidelines on state/federal cooperation. Best practice guidelines should be developed to be used by state and federal task forces, or one task force could be used to serve as the demonstration project.

In closing, I want to emphasize that the Medicaid Fraud Control Units are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The Units have been successful in serving as a deterrent to health care fraud, in identifying program savings, removing incompetent practitioners from the health care system, and in preventing physical and financial abuse of patients in health care facilities.

Mr. Chairman, I want to thank you for this opportunity to testify today and would welcome any questions you may have.

RECOMMENDATIONS TO DETER FRAUD IN MANAGED CARE ¹

- 1) Specify the individuals within each provider group who must personally sign the report of costs submitted during negotiations on capitation amounts. Ensure that these individuals sign under penalty of perjury.
- 2) Allow only "certified health care accountants" to prepare reports of costs. Require that to obtain this certification, accountants must receive specified training in health care finance and fraud. Require that each cost report include certification that a compliance audit has been conducted by a qualified health care accountant.
- 3) Structure enrollment procedures so that the entity regulating the providers enrolls consumers with a provider. Do not allow providers to enroll consumers. Establish data collection and retrieval systems to detect fictitious enrollment of consumers. (This presupposes implementation of uniform reimbursement and billing procedures.)
- 4) Require that all enrollment decisions be made directly by consumers or in the case of incapacity, by power of attorney or appointed guardians. Do not permit representatives of groups of consumers to make enrollment decisions.
- 5) To reduce the potential for collusion on reporting of costs or underprovision of necessary services, ensure that whenever possible, multiple providers, or multiple groups of providers, compete for patient enrollments.
- 6) Utilize the opportunities for self-regulation by providers. Require that to qualify to compete for enrollment by consumers, each group of providers must submit and have approved an anti-fraud, waste and abuse plan. Such a plan must address education, monitoring, detection and disciplining policies. In addition to their other duties, the entities managing the competition among providers should be charged with reviewing, approving and enforcing these plans as well as making referrals for prosecution in egregious instances.
- 7) Require that everyone who is financially able make copayments. Simplify claim forms and require a patient's signature on the claim form before the claim is submitted by the provider for reimbursement.
- 8) Recognize that if the poor are relieved from making copayments, greater potential for fraud exists in connection with delivery of care to the poor or the alleged poor. Additional fraud audits should be concentrated in services rendered to this population.
- 9) Recognize that a managed competition system presents a potential difficulty for enforcing the exclusion sanction. Neutralize this difficulty by giving law enforcement the tools needed to detect individual wrongdoers within an organization; by restructuring standards for finding organizations criminally liable; and, by protecting consumers in the event their provider is excluded.
- 10) Recognize that the managed competition system presents a potential for corruption. Ensure that law enforcement has the tools and training it needs to deter, detect and prove this corruption. Clarify the difference between illegal payments and legitimate contributions.

HEALTH CARE FRAUD CONTROL UNITS

LEGISLATIVE SUMMARY

Proposal: The proposal is intended to expand the jurisdiction of the Medicaid Fraud Control units and to allow them to investigate and prosecute fraud in other

¹Pamela H. Bucy, *Health Care Reform and Fraud by Health Care Providers*, 38 VILL. L. Rev. 1003, 1046-48 (1993).

federally-funded or mandated programs. The Units would continue to be the primary state components of a national health care fraud strategy. Existing statutory language was adapted to allow greater flexibility in addressing health care fraud in the states, wherever possible.

Need for Legislation: National discussions of health care reform include the folding of Medicaid benefits into state-based health care authorities/programs. Even without the passage of national health care reform, many states are seeking waivers from Medicaid requirements and are providing new and innovative state health care programs. Program integrity issues should be addressed at the same time these new health care delivery programs are established and approved.

Background: MFCUs are the single most successful agencies that investigate and prosecute health care fraud. The Units are also charged with investigating and prosecuting allegations of patient abuse and or neglect in facilities that receive Medicaid funds. The Units are justly proud of their accomplishments in protecting a very vulnerable segment of the population. In 1977, Congress recognized that rampant fraud existed in government funded or mandated health care programs when it passed the Medicaid and Medicare Anti-Fraud and Abuse Amendments. Since that time, 42 states have established MFCUs and, pursuant to recent legislation, nearly all states are expected to have Units by 1995.

Purpose of Legislation: This proposal would recognize the MFCU as a model for future state-based health care provider Fraud Control Units. The proposed statute would retain the essential elements of the MFCUs. These Units, at the very least, would be responsible for policing the Medicaid portion of any state program and, at most, for policing all federally-funded or mandated health care programs in the state. The Fraud Units will continue to be responsible for patient abuse investigations and prosecutions.

Funding Mechanisms: Currently, MFCUs are funded on a yearly grant basis with funds administered by the Inspector General for HHS. As MFCUs begin policing other components of federally-funded or mandated health care programs, it may be necessary to augment the Fraud Units' funding source to share the cost.

Oversight: To accomplish program integrity continuity, oversight should continue with the Office of Inspector General for HHS. Each participating Fraud Unit would detail its activities in its yearly grant applications. The grant applications would contain information so that the Inspector General could assess the scope of the Fraud Units' role in health care provider fraud.

PROPOSAL

STATE HEALTH CARE FRAUD CONTROL UNITS

For the purposes of this statute, the term "State Health Care Fraud Control Unit" herein after referred to as Fraud Units means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the requirements of this section. The Fraud Unit shall conduct a statewide program for investigating and prosecuting (or referring for prosecution) violations of any applicable state laws pertaining to fraud and patient abuse and neglect in any federally-funded or mandated health care program, the provision of medical assistance, or the activities of providers of services under any such health care program.

- 1) **Requirement.**—Each state shall establish and maintain a State Health Care Fraud Control Unit. Such fraud unit shall be the Medicaid Fraud Control Unit (as described in former section 1903 (q) of the Social Security Act) if the state has a certified Medicaid Fraud Control Unit and otherwise qualifies under this act.
- 2) **Organization and Location Requirements.**—The Fraud Unit must:
 - a) be a single identifiable entity of the state government;
 - b) be Separate and distinct from any state agency with principal responsibility for the administration of any federally-funded or mandated health care program; and
 - c) meet one of the following requirements:
 - 1) It must be a Unit of the office of the State Attorney General or of another department of state government which possesses statewide authority to prosecute individuals for criminal violations; or

2) If it is in a state the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, that (i) assure its referral of suspected criminal violations to the appropriate authority or authorities in the state for prosecution, and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions; or

3) It must have a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which provide effective coordination of activities between the Fraud Unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to any federally-funded or mandated health care programs.

3) Scope and Purpose.—The Fraud Unit must:

a) conduct a statewide program for the investigation and prosecution of violations of all applicable state laws regarding any and all aspects of fraud in connection with any aspect of the administration and provision of health care services and activities of providers of such services under any federally-funded or mandated health care programs;

b) have procedures for reviewing complaints of the abuse or neglect of patients of facilities that receive payments under any federally-funded or mandated health care programs. and, where appropriate, to investigate and prosecute such complaints under the criminal laws of the state or for referring the complaints to other state agencies for action; and

c) provide for the collection, or referral for collection to the appropriate agency, of overpayments that are made under any federally-funded or mandated health care program and that are discovered by the Fraud Unit in carrying out its activities.

The Fraud Unit may:

d) have procedures for reviewing complaints of abuse or neglect in residential facilities and in home health care programs that provide services to any person eligible to receive federally-funded benefits, including but not limited to, board and care and other residential facilities, and, where appropriate, for acting upon such complaints under the criminal laws of the state or for referring them to other state agencies for action.

4) Staffing Requirements.—The Fraud Unit must:

a) employ attorneys, auditors, investigators and other necessary personnel;

b) be organized in such a manner and provide sufficient resources as is necessary to promote the effective and efficient conduct of Unit activities.

5) Cooperative Agreements/Memoranda of Understanding.—The Fraud Unit must have cooperative agreements with:

a) federally-funded or mandated health care programs:

b) similar Fraud Units in other states, as exemplified through membership and participation in the National Association of Medicaid Fraud Control Units or its successor;

c) the Office of Inspector General for HHS and the Attorney General of the United States and his/her designee.

6) Reports.—The Fraud Unit must submit to the Inspector General for HHS an application and an annual report containing such information as the Inspector General determines to be necessary to determine whether the Unit meets the requirements of this section.

7) Federal Financial Participation (ffp) (MFCU transition to SHCFCU).

A State Health Care Fraud Control Unit shall continue to be funded at the rate of 75 percent ffp, 90 percent ffp if the Unit is within its first three years as a MFCU or as a State Health Care Fraud Control Unit. The transition period is from the status of a certified Medicaid Fraud Control Unit to a State Health Care Fraud Con-

trol Unit. At the conclusion of the three-year transition period, the State Health Care Fraud Control Unit shall receive funding at no less than 75 percent ffp.

8) Funding Approval.—In the annual report submitted to the Inspector General for HHS, the Fraud Unit shall describe its program for investigating and prosecuting health care provider fraud in any federally-funded or mandated health care programs. Upon approval of the annual report, the Inspector General shall grant funding to the Unit. The Inspector General may require whatever information is deemed necessary in the annual report to allocate Unit activities among any funding sources.

9) Funding Source.—The Fraud Unit may:

a) receive its funding from a number of sources. The Inspector General shall be responsible for administering the federal funds and for allocating the funds to the Units from the various funding sources or programs.

b) The Fraud Unit shall participate in any trust fund established for the specific purpose of funding health care provider fraud investigations and prosecutions.

AMENDMENTS REQUIRED/STATUTES AFFECTED

42 U.S.C. § 1396b(a)(6)—amend to extend funding.

42 U.S.C. § 1396b(b)(3)—amend to change cap either to reflect Medicaid portion of Unit budget or to cap Unit size.

42 U.S.C. § 1396b(q)—this proposal amends this section by adding the necessary language to adapt the status of the Medicaid Fraud Control Units to new health care programs; to outline program requirements, the percentage of federal funding, and to identify the oversight agency.

42 C.F.R. Part 1007—must be rewritten to reflect this proposed legislation and more detailed program mission.

HEALTH CARE PROVIDER FRAUD: THE STATE MEDICAID FRAUD CONTROL UNIT EXPERIENCE

EXECUTIVE SUMMARY

Medicaid Fraud Control Units are federally funded state law enforcement entities which investigate and prosecute Medicaid provider fraud and violations of state laws pertaining to fraud in the administration of the Medicaid program. In addition, the Units are required to review complaints of patient abuse and neglect in all residential health care facilities that receive Medicaid funds. The Units are staffed by attorneys, investigators and auditors trained in the complex litigation aspects of health care fraud. The Units are required to be separate and distinct from their state Medicaid programs and are usually located in the state Attorney General's office.

There are 41 federally certified Medicaid Fraud Control Units (MFCUs). Since the inception of the Medicaid Fraud program in 1978, the Units have successfully prosecuted over 6,000 cases and have been responsible for identifying and returning hundreds of millions of program dollars. It is important to note that every criminal conviction excludes the provider from participation in both the Medicaid and Medicare program as well as other federal health care programs. The Units are also responsible for protecting the frail elderly who reside in nursing homes, some of the most vulnerable of our population.

The National Association of Medicaid Fraud Control Units which represents the 41 state MFCUs undertook this analysis to provide its insight on fraud in managed care. The findings in this paper are drawn from the Units' fifteen years of experience in investigating and prosecuting health care provider fraud.

Current fraud schemes include: billing for services not rendered, double billing, misrepresenting the nature of services provided; providing unnecessary services; illegal remunerations and false cost reports.

Based on our common experience, the National Association of Medicaid Fraud Control Units concludes:

- A provider who submits false claims to Medicaid often submits false claims to other government programs and to private insurance payers. Increasingly, the cases of many fraud units include a component of private insurance fraud as well as other government program fraud.

- The Units are structured such that they provide the most efficient and effective use of resources to successfully handle health care provider fraud at the most logical governmental level, the states.
- The Units have accumulated a wealth of experience in these highly complicated white collar crime cases that would be difficult to duplicate or replace.
- No health care plan is immune from fraud, but rather the fraud simply takes different forms in response to the way the program is structured.
- Fraud occurs in managed care plans.

State MFCUs have documented several types of criminal activity in managed care plans including: fraudulent subcontracts; fraudulent related party transactions; excessive salaries and fees to participating entrepreneurs; bribery, tax evasion, kickbacks, rebates and other illegal economic arrangements; and fraud in the administration of the program.

- Quality of care problems occur more frequently in managed care programs than in the traditional fee-for-service payment programs.

These problems include underutilization of necessary services, falsification or misrepresentation of professional credentials by providers and the use of unlicensed providers.

Patient and resident abuse will continue to occur.

- Unscrupulous providers will find new and innovative ways to criminally profit at the expense of patients and health care payers.
- A program for the detection and prosecution of those who will prey on any health care delivery system should be included in the new system.

The ancient law looked upon fraud as a greater crime than theft, and, therefore, seldom failed to punish it with death, for with care and vigilance and a very common understanding might a man preserve his goods from thieves, but honesty has no defense against superior wit and cunning.

ANONYMOUS (1726)

HEALTH CARE PROVIDER FRAUD: THE MEDICAID FRAUD CONTROL UNIT EXPERIENCE STATE MEDICAID FRAUD CONTROL UNITS (MFCUS)

Medicaid Fraud Control Units are federally funded state law enforcement entities which investigate and prosecute Medicaid provider fraud and violations of state laws pertaining to fraud in the administration of the Medicaid program. In addition, the Units are required to review complaints of patient abuse and neglect in all residential health care facilities that receive Medicaid funds. The Units are staffed by attorneys, investigators and auditors trained in the complex litigation aspects of health care fraud. The Units are required to be separate and distinct from their state Medicaid programs and are usually located in the state Attorney General's office.

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The National Association of Medicaid Fraud Control Units represents the 41 federally certified units and is staffed by a Medicaid Fraud Counsel who conducts its daily work at the office of the the National Association of Attorneys General, in Washington, D.C.

The Association was founded in 1978 to provide a forum for a nationwide sharing of information concerning the problems of Medicaid fraud: to foster interstate cooperation on legal and law enforcement issues affecting the Units; to improve the quality of Medicaid fraud investigations and prosecutions by conducting training programs and providing technical assistance to Association members; and to provide the public with information about the Medicaid Fraud Control Unit Program.

The Association conducts several training conferences yearly and publishes a newsletter, the *Medicaid Fraud Report*, 10 times a year.

HISTORY OF THE PROGRAM

As a preface, it is worth noting the historical context of the MFCU program. Medicaid was created by Congress in 1965 as a national attempt to provide uniform health care benefits for the financially indigent. Initially, no fraud and abuse provisions were contemplated nor enacted. Congress, in the mid-1970's, became aware of widespread fraud and abuse by health care providers in the Medicaid Program when it conducted hearings which documented evidence of provider fraud. These hearings revealed that fraud and abuse were taking a toll on the beneficiaries as well as on the ability of the states to deliver these federally mandated health care services.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142), signed by President Jimmy Carter on October 25, 1977, were designed to strengthen the capability of the government to detect, prosecute and punish health care fraud. The key to the success of the MFCUs are the following statutory requirements: the Units must be separate and distinct from the Medicaid agency; are generally located in the state Attorney General's office; must be solely dedicated to investigating and prosecuting provider fraud and patient abuse; must be staffed by trained specialists, i.e. attorneys, investigators, and auditors who are trained in the prosecution of complex white-collar crime cases; and must have statewide prosecutorial authority or the ability to establish formal procedures with the appropriate state prosecuting authority.

Many believe that the gap between the establishment of the Medicaid Program in 1965 and the establishment of the MFCUs in 1977 forced law enforcement into a nearly impossible catch-up mode. New health care fraud schemes and new twists to old schemes are documented every day. Health care providers are no exception to those who would cheat a system where a large amount of money is administered. Criminal health care fraud not only diverts scarce resources but also deprives those who are in need of health care. In addition, fraudulent health care providers are sometimes found to be incompetent.

As Professor Pamela Bucy so accurately points out in her exhaustive law review article on health care fraud,¹ the growing commercialization of health care encourages fraudulent behavior. Furthermore, Professor Bucy states, as the number of providers increase, and the efforts to control health expenditures increase, there will be fewer dollars to be divided among the provider community. "As providers seek to maintain what they perceive as appropriate target incomes, the unscrupulous provider is more likely to succumb to fraud."² Some health care professionals and non-professionals literally scheme and plot ways to get around any new rules, regulations, or controls and continue to divert large amounts of program dollars for their own benefit. While the vast majority of health care providers are honest, health care is a big business and big business without regulatory and legal controls sets the stage for fraud. Health care provider fraud undeniably exists and affects both government and private insurance payers. We urge you to not repeat what should be a lesson of history. When a new health care delivery system is chosen, program for the detection and prosecution of those who will defraud it, should also be created.

CURRENT FRAUD SCHEMES

1. Billing for services not provided

This is one of the most common types of abuse. Examples include, a provider who bills Medicaid for a treatment or procedure which was not actually performed, such as blood tests when no samples were drawn, x-rays which were not taken, or, in the case of a dentist, billing for a full denture plate when only a partial was supplied. It is improper for a Medicaid provider to bill Medicaid for any service not performed.

2. Double billing

A provider will bill both the Medicaid Program and a private insurance company (or the recipient) for the treatment. Another example is two providers requesting payment for services rendered to one recipient for the same procedure on the same date.

3. Misrepresenting the nature of services provided

A pharmacy may bill the program for the cost of a prescription drug charging the name brand prescription drug price, when, in fact, a generic substitute was supplied

¹Pamela H. Bucy, *Fraud By Fright White Collar Crime by Health Care Providers*, 67 N.C. L.Rev. 855, 856 (1989).

²*Id.* at 936.

to the recipient at a substantially lower cost to the pharmacy. Less expensive goods are often supplied to a patient but a higher priced item is billed for.

4. *Providing unnecessary services*

A provider may misrepresent the diagnosis and symptoms on recipient records and billing invoices to obtain payment for unnecessary tests and procedures.

5. *Illegal remunerations*

A provider, for example, a nursing home operator conspires with another health care provider, i.e. physical therapist, pharmacy, laboratory, ambulance company or physician, to pay a certain portion of the monetary reimbursement the health care provider receives for services rendered to patients in the nursing home. Payments include, vacation trips, leased vehicles or other remuneration. This practice usually results in unnecessary tests and services being performed for the purpose of generating additional income.

6. *False cost reports*

A nursing home owner or hospital administrator may include inappropriate expenses in claims to Medicaid. These expenses often include the costs of items for personal consumption and use.

FRAUD IN OTHER GOVERNMENT PROGRAMS/PRIVATE PAYERS

The fraud units have found that a provider who submits false claims to Medicaid very often submits false claims to other government programs and to private insurance payers. Increasingly, the cases of many fraud units include a component of private insurance fraud as well as other government program fraud (i.e. Medicare and CHAMPUS prosecuted in conjunction with Medicaid fraud cases).

In order to successfully investigate and prosecute providers of any health care program, one must understand the program's rules and regulations. As a result of this increasing experience with a variety of health care reimbursement systems, the Units have gained a wealth of experience that would be difficult to duplicate or replace.

FRAUD IN MANAGED CARE PROGRAMS

Both the Medicaid and Medicare programs have experimented with managed care. In some states, managed care has been in existence since the early 1980's. Recently, more states are requiring greater numbers of their Medicaid population to participate in their managed care programs.

Proponents of the managed care system believe that it is the best method for providing low cost high quality health care to more people. Managed care is not only supposed to save money but it is also designed to cut down on the amount of paperwork. While many observers point out that the very nature of managed care prevents fraud, the experience of the fraud units, the Arizona Unit in particular, the Medicare program and the private insurance industry, reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans. Rather, fraud simply takes different forms, in response to the way the program is structured.

While the traditional Medicaid provider fraud investigation focuses on overutilization of services and fraudulent billing and seeks as the ultimate aim accountability for claimed services, in managed care investigations, the evil more likely lies in the underutilization of services.³ Unlike the typical Medicaid provider fraud case, the human cost in terms of reduced access to quality care may be tremendous.⁴

THE ARIZONA EXPERIENCE

The Arizona Health Care Cost Containment System (AHCCCS), a statewide prepaid capitated program, that is designed to provide the same quality health care to the poor that is provided to private pay patients, began on October 1, 1982. Each recipient is enrolled in a health maintenance organization (HMO or AHCCCS Plan), which in turn contracts with the state to provide all benefits for a fixed fee per enrollee. Plans bid competitively by county. The AHCCCS Fraud Unit was established on November 5, 1984, and has 8½ years of experience in investigating and prosecuting fraud in the AHCCCS Program.

³ Cathy Pilkington, *Health Maintenance Organizations: Investigating Industry-Wide Practices, Medicaid Fraud Rep.*, Feb. 1988, at 1.

⁴ *Id.*

AHCCCS is operated by private plans, which may be for-profit, rather than administered directly by the state. Federal and state monies are the payment source for these for-profit plans that actually provide care to the beneficiaries. Each of these private plans represent opportunities for entrepreneurial fraud.

I. False claims

Because AHCCCS has a limited fee-for-service component of its system, the AHCCCS Fraud Unit has found numerous examples of a traditional type of fraud, that is, the submission of false claims. The AHCCCS program is a two-tier system, the state agency pays certain types of claims directly, and the subcontracted plans pay other types of claims. The AHCCCS Fraud Unit has found that false claims have been submitted at both levels.

At the state level, the submission of false claims involves mainly upcoding and double-billing. While there are many types of upcoding the primary type that the AHCCCS Fraud Unit has discovered is billing for a higher level of service than actually provided. For example, physicians have billed for a Level II ultrasound when they have really performed a Level I, have submitted claims for a comprehensive consultation when they have only performed an examination or merely admitted a patient, and have submitted claims for a more complex surgical procedure than actually performed.

The AHCCCS system enables providers to double-bill that is, they can bill for the same service at the state level as well as at various subcontracted levels because the system which has different payers or beneficiaries, is so complex.

At the plans' subcontractor level, the AHCCCS Fraud Unit has found that false claims have been submitted by virtually every provider type; physicians, osteopaths, medical transportation companies hospitals, pharmacies, physical therapists, registered nurses, etc. These false claims involve the following schemes:

Upcoding; billing for services or supplies not provided; several types of unbundling (split billing, breaking services down into steps and stages, billing for services included in the single fee, etc.); billing for unnecessary services, duplicate billing; hospital bill padding; pharmacy fraud (generic substitution, short filling; false refilling; forged prescriptions); billing for services provided by others; and false time claims by health care workers.

No one health care entity can effectively cover all services that will be needed by a plan's beneficiaries. Therefore, some fee-for service component will continue to exist as part of any managed health care plan and, the types of fraud that are inherent to the traditional delivery system will continue to exist.

II. White-collar crime

"Fraud by health care providers is one of the most deleterious of all white-collar crimes."⁵

The AHCCCS Fraud Unit has learned that any managed care system that allows profit-minded entrepreneurs to be involved will be subject to traditional white-collar crimes. In fact, the government is often victimized twice, first by failing to receive performance on its prepaid capitation contracts, and then again by having to pay for services to the beneficiaries when the vendors fail to provide them. In some cases, the subcontracting provider may actually be the victim, by providing the care and then not getting paid for that care by the contracted plan.

Specifically, Arizona has documented the following types of criminal cases:

Embezzlement of funds paid by the state to plans for client services; theft of funds, equipment and services; fraudulent subcontracts (for example, no services provided, or phony management contracts); fraudulent related party transactions; excessive salaries and fees to the entrepreneurs involved; extortion; conspiracy; mail and wire fraud; bribery; tax evasion; and, pure and simple bustouts (money goes in, no money goes out to the vendors, then the entrepreneur claims bankruptcy).

In general, the white-collar crime aspect of the AHCCCS program has been exacerbated by inadequate investigation and supervision of the subcontractors, poor monitoring of plan activities and providers by the subcontracted plan, and inadequate operation and financial reviews.

III. Kickbacks/rebates and other illegal economic arrangements

Arizona is becoming increasingly aware of a growing number of situations involving kickbacks. Examples of kickback cases include: money from one provider to an-

⁵ Bucy, *supra* at 855.

other provider (for example, for referral of patients); from a subcontracting plan to a provider (or employee of a provider); from one subcontractor to another subcontractor, and from an unlicensed provider to a licensed provider for the use of his license. Also, Arizona has found providers sharing capitation payments with each other subsequent to an "arranged" assignment of patients. Due to the complex structure of the AHCCCS managed care program, and the many types and levels of providers, there are opportunities for kickbacks among providers. Thus far, Arizona has found physicians, osteopaths, home health care facilities, durable medical equipment companies, and physical therapists involved in kickbacks. In general, kickbacks are a very difficult type of fraud to detect and prosecute.

IV. Fraud in Government administration / lack of internal controls

Arizona has recently begun to take more of an interest in the actual administration of the AHCCCS managed care program and is discovering reason for concern at the state administrative level. Along the kinds of fraud that have been, or are being, reviewed are bid rigging by state personnel (collusion with the bidders); self-dealing by state and county employees; and numerous types of conflicts-of-interest by state employees in their dealings with the plans.

This type of problem is inherent in any business organization or governmental program and should be addressed by a strong regulatory effort to vigorously educate and monitor staff with respect to conflicts-of-interest, and to regulate and enforce laws dedicated to exposing and discouraging these relationships. The agencies that regulate the health care plans must be required to cooperate with the investigative agency or law enforcement entity that is charged with ferreting out fraud. Under current Medicaid regulations, the state Medicaid agency is required to refer suspected cases of fraud and abuse to the MFCU.

V. Miscellaneous frauds / collateral criminal activity

There are other kinds of fraudulent activity that Arizona has discovered which may not fit into any convenient category and include:

- 1) Providing Medicare and Medicaid services when the provider has been previously excluded from the programs. This could occur as a result of providers who have been excluded based on a criminal conviction or license proceedings.
- 2) Forging professional credentials to gain employment in an AHCCCS contracted facility.
- 3) Exploiting the Medicaid funds of incapacitated adults. Arizona has numerous examples of the embezzlement of patients' trust funds or assets by nursing staff or family members, by false powers of attorney and forgeries, by impersonating licensed health care professionals in order to exploit an AHCCCS client, and by diverting the Social Security checks of AHCCCS clients for unauthorized uses.
- 4) Providing false information on applications to qualify for AHCCCS. This includes financial and other information used to make contractual decisions.

THE EXPERIENCE OF OTHER STATES

As previously described, more states are requiring Medicaid beneficiaries to participate in managed care programs. For example, while managed care in Michigan has existed in various forms since 1982, the state Medicaid agency has been aggressively pursuing the managed care option during the past two years and anticipates that by December, 1994, 60 percent of the Medicaid population in Michigan will become part of the managed care system.

The Michigan program consists of three types of managed care; physician sponsored plans, clinic plans and HMOs. The MFCU has had experience in dealing with fraud in both the physician sponsored plans as well as the clinic plans. The physician sponsored plans run the gamut of fraudulent activity from kickbacks to billing for services not rendered. This plan is very similar to the traditional fee for services payment system with Medicaid providers.

Although a limited number of clinics operate under the managed care system in Michigan, the MFCU is currently investigating a clinic in Detroit that it anticipates charging with Medicaid fraud and other crimes in the near future. This is an enrolled Medicaid clinic that utilizes unlicensed doctors and physicians' assistants. Although the Michigan MFCU has less experience with HMOs, it does note that they are subject to kickbacks. Typically, the HMOs have no internal mechanism to monitor fraud.

Illinois has also had prepaid, preventive health care for Medicaid recipients since 1982. The Illinois MFCU began an investigation into prepaid health plans in 1987

and found fraudulent marketing techniques, reduced access to quality of care and improper disenrollment practices. The Unit learned that misleading or downright fraudulent marketing practices are a common complaint in the Medicaid HMO population. At the time the investigation began, the Unit learned that many HMO salesmen worked on a "quota system." Under the quota system salesmen were required to enroll a certain number of recipients per week. The Unit learned of instances in which salesmen not meeting quotas lost their jobs or were threatened with termination. The incentive to enroll recipients at any cost, coupled with recipient misunderstanding of the consequences of HMO enrollment seems to have caused tremendous problems in Medicaid HMO enrollments.

A further category of complaints pertained to HMO disenrollment practices. Recipients complained that upon becoming dissatisfied with HMO health care, disenrollment was made very difficult. Recipients who desired to disenroll were advised to take a bus trip to downtown Chicago. Some recipients described hours long waits in HMO reception rooms before obtaining appropriate forms. Even after travelling downtown and filling out forms, changing health care providers allegedly took several months.

In California, the state has enrolled 1.1 million Medi-Cal beneficiaries in 1993 and expects to enroll 2.5 million beneficiaries by the end of 1994. Fifty percent of the Medi-Cal population (Medi-Cal is the Medicaid program in California) will be enrolled by the end of 1994. The program expects to spend \$15 billion in the upcoming year. Existing HMOs will participate by accepting Medi-Cal beneficiaries.

In California's managed care system, the single state agency (Medicaid agency) contracts for some or all of its Medicaid covered services and supplies. The services are provided by employees of the contractors or by subcontractors. The victim of fraud may be the program, the contractor, the subcontractor or the individual provider. The perpetrator of fraud may be an individual within the single state agency, an individual employed by the contractor or subcontractor, or individual provider, agent, employee or an entity that controls the service provider.

Huge dollar amounts are at stake in California's managed care program unlike the average individual provider. While Medicaid and/or Medicare providers who have been convicted of health care fraud are subject to civil fines, sanctions and exclusion from the programs, managed care plans would suffer a far greater financial loss if sanctioned or excluded from participation in the health care delivery system. The system would suffer the loss of a major provider and therefore the ability to deliver health care to large numbers of beneficiaries.

Some potential areas of fraud that the California Unit has found include the following:

a contractor arbitrarily excludes identifiable groups of beneficiaries (people with mental/emotional problems children, infants, elderly) from service even though these people were assigned to one plan; a contractor denies treatment requests regularly or by policy without regard to legitimate medical evaluation; a contractor has policies that require an appeal prior to providing the treatment; a contractor relies strictly on the language of the contract and only measures performance by breach of contract concepts; a contractor fails to notify assigned beneficiaries of their right to services yet keeps a capitated sum; a contractor fails to obtain health practitioners thus no service is supplied; a contractor retains an exorbitant "administrative fee" releasing too little to the subcontractor or individual provider to cover their costs; a contractor keeps an administrative fee but fails to monitor shortcomings of the subcontractor; and a contractor attempts to assign too many beneficiaries to providers of service thus making adequate service impossible.

Maryland recently initiated a managed care approach for a large percentage of its Medicaid enrollees. It has already become apparent that a problem will occur with respect to the quality of patient care being afforded by some of the more unscrupulous providers participating in the program. This "quality of care" issue is directly attributable to the desire of providers to increase their reimbursement from the Medicaid program and other insurers.

Specifically, the Maryland MFCU is now investigating an internist who, although a solo practitioner, is attempting to treat up to ninety Medicaid patients during his five-hour work day. Needless to say, the actual medical care rendered is minimal (at best) and the cost to the state Medicaid Program is exorbitant—up to \$42.50 per patient. The Unit has learned that his "private pay" patients receive a more complete routine examination while the typical Medicaid recipient on managed care receives what one would generously call an abbreviated service, regardless of the symptoms with which they present.

The Unit recently learned of another managed care provider who went on vacation and left a message on his answering machine telling his patients that if they had a medical problem, they should seek assistance at a hospital emergency room.

In addition, the Unit has received an allegation concerning a Baltimore HMO which paid cash incentives to its sales staff, the amounts of which were determined by the number of new enrollees they were able to attract. This practice is alleged to have led to falsification of new enrollee registrations, leading to increased and false charges to third-party insurers, including Medicaid.

MEDICARE/HMO FRAUD

In the early 1980's, concerned with the skyrocketing costs of health care, Congress evaluated the efficiencies of HMOs as a way to save dollars for Medicare while providing high quality, coordinated benefits. Given appropriate safeguards on access and quality, it was assumed that Medicare could save billions of dollars by giving older Americans the option to participate in a system of health care delivery that had already attracted increasing numbers of younger individuals.

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Congress authorized the Medicare program to contract with HMOs for covering beneficiaries on a "risk" basis. Under a risk contract, the HMO would provide the full range of Medicare benefits for a fixed cost for each enrollee. If the actual costs of services were higher than the payment, the HMO would absorb the loss. Thus, the concept of risk.

The first risk contracts were signed in April 1985. As of March 1, 1987, about 3 percent of the Medicare population—867,087 individuals—were enrolled in 151 HMOs under risk contracts.

In addition to traditional HMOs Congress authorized "competitive market plans" (CMPs) which were groups of providers who came together for the purpose of contracting with Medicare to supply flat fee paid health care services to defined Medicare populations. In 1987, the late Senator John Heinz, then ranking member of the U.S. Senate Special Committee on Aging, conducted an investigation of the Medicare HMO and CMPs alternative program. The following results were documented in the Committee's report, *Medicare and HMOs: A First Look with Disturbing Findings*, and may be relevant to determine where fraud and abuse may occur in these non-traditional delivery programs.

Providers were found to manipulate the beneficiary pool in an attempt to remove higher risk (more expensive) participants. Reducing health care costs of any participant increases profits. Marketing practices of the plans were found to be misleading in some cases and even false. Quality of care was found to be inadequate because medical judgments became the basis for profits. In at least one instance the provider, International Medical Centers (IMC), a Florida HMO, falsified its financial background, denied access to beneficiaries, and went bankrupt after diverting pre-paid sums causing Medicare to have to intercede and pay twice for the care of the IMC's beneficiaries.

The illegal schemes used by these plans included: pre-enrollment health screening of potential enrollees; selective marketing practices; denying access to high cost beneficiaries in an attempt to have them withdraw from the plan; and geographically terminating the plans coverage to remove high cost beneficiaries.

Subsequent legislation banned the use of physician incentives by hospital and Medicare HMOs. The incentives were designed to put undue and clinically inappropriate pressures on physicians to limit care.

The lesson of international medical centers

In 1981, the Miami-based International Medical Centers received federal government approval to provide comprehensive medical care to Medicare patients. For a flat payment of 95 percent of Medicare's normal per-patient costs, all the health care needs of the enrollees would be taken care of.⁶ Even free prescriptions, eyeglasses and hospital care without Medicare's deductibles were promised. The Regan administration believed that IMC would be the national model for low cost, high quality health care for the elderly. IMC ultimately became the country's largest Medicare HMO, enrolling more than 130,000 elderly Florida residents and costing the government approximately \$360 million annually.

IMC enrolled such a large number of beneficiaries because of a large television advertising campaign as well as aggressive and high-pressure door-to-door sales techniques.

⁶This discussion of IMC is excerpted from an article by Michael Abramowitz, *Collapse of a Health Plan: How Did Such a Good Idea Turn Out So Bad?*, Wash. Post, June 23, 1987 at A1.

However, as a result of the rapid and unexpected enrollment of so many beneficiaries, IMC became overburdened and unable to pay its bills or provide adequate care. There were allegations that IMC officials paid themselves unusually large salaries for an HMO.

IMC finally collapsed only five years after it began because of alleged mismanagement and failure to maintain adequate capital. Furthermore, both the Inspector General of HHS and the FBI investigated allegations of fraud. The founder of IMC, Miguel Recarey, Jr., was indicted by a federal grand jury in Miami for conspiring to bribe union officials to send patients to the health plan and charges of fraud, racketeering, wiretapping and bail-jumping.

As of July 1992, the FBI was still pursuing Recarey who had fled the country in 1988 supposedly to Venezuela.⁷

FRAUD IN PRIVATE INSURANCE/MANAGED CARE

In addition to the government's attempts to reduce costs by encouraging the establishment of managed care systems, the private insurance industry has also steered more of its beneficiaries into managed care plans. And private insurers have also found fraud in these plans. Some industry observers believe that preferred provider arrangements (PPAs) are more susceptible to fraud because there are fewer controls, therefore there's more incentive to increase or fabricate charges.

QUALITY OF CARE

Quality of care problems occur more frequently in managed care systems than in the traditional fee-for-service. While the success of the MFCUs in discovering and prosecuting Medicaid provider fraud is widely recognized, it is less well known that they have jurisdiction over complaints of patient mistreatment in residential health facilities that receive Medicaid funds. When Congress held numerous hearings on Medicaid fraud in the 1970's, egregious cases of patient abuse and neglect in nursing homes were described and Congress soon realized that in the institutional setting poor quality of care was often the result of fraud by nursing home owners and operators. For example in its investigation of the state's nursing home industry, in the mid 1970s, the New York Office of the Special Prosecutor for Medicaid Fraud Control found that patients suffered dramatically because the Medicaid money that was to be used for the care of patients was diverted into the hands of greedy nursing home operators. The result of this greed was patients who were horribly neglected, many of whom developed decubitus ulcers and were literally left to rot in their own waste. Because of these scandals, Congress authorized the MFCUs not only to investigate and prosecute Medicaid provider fraud but also to investigate allegations of patient abuse and neglect in nursing homes. After more than a decade of investigating patient and resident abuse, neglect, mistreatment and economic exploitation, the state MFCUs have established that patient abuse crimes pose a significant threat to the safety and well-being of the elderly and sick residing in health care institutions.

In managed care plans, the types of quality of care fraud issues that occur include the denial of medically necessary care and the delivery of substandard and generally inappropriate health care. The Illinois MFCU, for example, found that a significant number of the complaints made to the Unit alleged that recipients seeking medical treatment had been turned away or told to make appointments several weeks in the future. In some instances, recipient ignorance or misinformation regarding HMO health care precipitated the problems. Recipients were unaware that upon HMO enrollment, they would be essentially restricted to one location. Certain recipients alleged that upon enrolling in an HMO, they were assigned to clinic locations miles away from their homes. No longer could they merely walk to the neighborhood clinic to seek medical treatment. Admission to a hospital or even an emergency room visit now required the consent of the HMO. As the investigation progressed, Unit personnel learned that physician incentive payments were a common practice in HMOs. Essentially, this means that physicians on contract to the HMO receive monies left-over for hospital days not used or for surgery not performed, etc. A fair amount of physicians called to complain that their medical judgments were, at times, being replaced by what they felt were improper cost containment considerations. Therefore,

⁷Michael Isikoff, *As Race Heats Up, So Does Scrutiny of Bush's Family, Relatives' Business Affairs Become Target*, Wash. Post, July 4, 1992, at A1.

in some instances, it appeared that underutilization of services and the potential for interference with medical judgments was a problem.⁸

The underutilization of services, the falsification or misrepresentation of professional credentials by providers and the use of unlicensed professionals all of which have been seen in managed care plans, will surely affect the quality of care and could indeed lead to patient abuse. Furthermore, although the health care delivery system may change, a large portion of health care services will continue to be delivered in hospitals and nursing homes and just as fraud will continue to exist, so will patient and resident abuse.

UNDERUTILIZATION

Crimes involving "overutilization" result in providers ordering tests, medical equipment, and other services which are not medically necessary but do result in a greater profit to the provider. In a program which attempts to cap costs or establish contractual flat fee payments to supply a beneficiaries' health care, a motive is created to accept payment and supply as few services as possible thus maximizing profits. The same provider who currently lies about the necessity of a test for profit, will also lie about the need for a necessary test in order to reduce costs and retain a higher level of profits. "Underutilization" takes a number of forms to include falsifying medical records which would support the need for treatment or altering medical decisions (for example, a patient needs a complex and expensive battery of tests) to avoid the expense. if the duty that is contractually established is to supply a certain level of health care benefits, a knowing and willful refusal to supply agreed and necessary services should be a crime.

U.S. V. NATIONAL HEALTH LABORATORIES

A case study in the manipulation of medical judgment for profit

National Health Laboratories (NHL), a publicly traded corporation, is one of the largest medical laboratory chains in the country. In 1987, NHL instituted a marketing and billing scheme which ultimately cost the Medicaid and Medicare programs millions of dollars. One of the most disturbing aspects of NHL's scheme involved a small, greedy group of business executives who devised a method to circumvent the medical judgment of thousands of medical doctors for the corporation's gain. NHL's scheme involved adding an expensive blood test to a standard panel test. Through aggressive and deceptive marketing techniques, the corporation managed to double and then triple its profits using the scheme over a three year period. In the end, NHL used the thousands of tests ordered by physicians to imply that the doctors medical judgment extended to the tests added by the company. An important lesson of the *U.S. v. NHL* case is that the government should be careful in trusting a for-profit business entity in making medical judgments.

This case also illustrates the scope of health care fraud and its national implications. In December of 1992, NHL and its president/chief executive officer entered guilty pleas in United State District Court for the Southern District of California in San Diego. The defendants agreed to repay \$110.5 million dollars to Medicare and 33 state Medicaid programs. This case is the largest health care prosecution ever and represents a high point in the cooperation of 33 state Medicaid Fraud Control Units aid with federal prosecutors. It is of note that this prosecution involved: ancillary services not physician care; tests actually performed and not fictitious billing; the manipulation of the concept of medical judgment and necessity for a profit; a large national corporation and not a primary provider or clinic; and a group of profit minded unscrupulous businessmen in search of a way to maximize their company's profits at the expense of government and health care beneficiaries. NHL also exemplifies the ability of the states to coordinate and cooperate both with each other and with the federal government on health care fraud cases. If the new health care delivery system establishes entities that cross state lines, the state MFCUs can be looked to as a model of state law enforcement agencies that are capable of handling multi-jurisdictional health care fraud cases.

CONCLUSION

Health care fraud occurs and will continue to occur in the future no matter what type of delivery system is created. Our experience has shown that unscrupulous providers have always found new and innovative ways to criminally profit at the expense of patients and health care payers. If there is a larger amount of health care

⁸ Pilkington, *supra* at 3.

fraud than in the past, it may be attributable to the growing size of the industry and the diversity of the services that are considered to be a part of "health care." All payment programs have relied heavily on the integrity of those with whom they have contracted and too often the expectation that the provider is honest and believes that the patient's health is of paramount concern has not been realized.

Unfortunately, as James Pinkerton predicted in his article in *New York Newsday*, March 18, 1993 "About 10 minutes after the President signs a bill, Americans will figure out how to 'game' the new system. The cleverest doctors and lawyers in the country will match wits with bureaucrats. Guess who will win."

A program for the detection and prosecution of those who will prey on any health care delivery system that is designed should be a part of the Administration's report on health care reform.

RECOMMENDATIONS ON HEALTH CARE FRAUD ENFORCEMENT BY THE NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

I. The state Medicaid Fraud Control Units (MFCUs) should be incorporated immediately into any new health care delivery system. If the Medicaid Program is eliminated and becomes part of the new health care delivery system, the newly named state health care fraud units should have the same authority as the current state MFCUs, that is, the statewide authority to prosecute providers for criminal violations and to investigate allegations of patient abuse and neglect in facilities that receive government monies and to investigate and prosecute violations of all state laws pertaining to fraud in the administration of the program. Such Units should be mandatory for all states.

II. In addition to leaving the same authority as the current MFCUs, the new state health care fraud units should be staffed by trained specialists, i.e. attorneys, investigators and auditors who are trained in the prosecution of complex white-collar crime cases.

III. The Units should be solely dedicated to the investigation and prosecution of provider/administrator/contractor fraud and patient abuse.

IV. A Unit should be located in the office of the state Attorney General or another department of state government which has statewide authority to prosecute individuals for violations of criminal laws with respect to fraud in the provision or the administration of the program. If there is no state agency with statewide authority and capability for criminal fraud prosecutions, the Unit should establish formal procedures that assure that the Unit refers suspected cases of criminal fraud to the appropriate state prosecuting authority or authorities.

V. A Unit must be separate and distinct from the state health care agency. No official of the state health care agency will have the authority to review the activities of the Unit and the Unit should not receive funds either from or through the health care agency.

VI. The state health care agency must cooperate and ensure access to records maintained by the agency or its contractors to the fraud control unit. The Unit will enter into an agreement with the state health care agency under which the state health care agency will agree to refer all suspected cases of provider fraud to the Unit.

VII. The new state health care entities should have methods and criteria for identifying suspected fraud cases and procedures, developed in cooperation with state legal authorities, for referring suspected fraud cases to the Units. The new state health care entities should also have internal methods for detecting suspected fraud.

VIII. The fraud control units should have the authority to investigate and prosecute fraud that is committed by a health care provider, administrator or contractor against any government third party payer (including Medicare) or private payer.

IX. No specific recommendation can be made regarding the funding of these Units without further information about the new delivery system. Funding should be a partnership between state, federal, and possibly private payers with incentive funding to encourage state enforcement and funding levels proportionate to the expenditures of the system.

NATIONAL ASSOCIATION OF ATTORNEYS GENERAL

ADOPTED RESOLUTION ON HEALTH CARE FRAUD

WHEREAS, the cost of health care continues to rise dramatically every year and millions of Americans are uninsured and underinsured; and

WHEREAS, estimates of health care fraud in government and private insurance programs range from \$580 to \$100 billion each year; and

WHEREAS, health care fraud is of increasing national concern and a focus of both law enforcement and the private insurance industry; and

WHEREAS, Congress is considering numerous proposals to reform the health care delivery system in order to contain costs and to assure access to quality health care for all, and several of these proposals would restructure or eliminate Medicaid; and

WHEREAS, health care fraud has been the subject of numerous Congressional hearings and proposed legislation; and

WHEREAS, Medicaid finances the majority of long term care costs and with the aging of the population it is vital to continue to protect the quality of care of those sick and elderly who reside in health care facilities; and

WHEREAS, the states have demonstrated their success for more than a decade in investigating and prosecuting health care providers and in protecting sick and elderly residents of health care facilities from patient abuse and neglect; and

WHEREAS, the Medicaid Fraud Control units of the states and the District of Columbia have demonstrated their ability to coordinate their resources with other state and federal agencies, which is necessary to successfully prosecute these crimes; and

WHEREAS, if Congress adopts a new health care financing system that eliminates Medicaid, the government will still be significantly involved with financing health care, there will be enormous sums of money involved, and there will continue to be unscrupulous providers who steal public funds; and

WHEREAS, Congress should establish integrated law enforcement units that have statewide authority to prosecute providers for criminal violations and should include these state investigative and prosecutorial entities immediately in any proposed health care reform legislation;

NOW THEREFORE, BE IT RESOLVED THAT THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL:

- 1) urges Congress to continue to maintain state investigative and prosecutorial entities in any new health care reform legislation; and
- 2) urges Congress when adopting fraud and abuse legislation to use the Medicaid Fraud Control Units of the states and the District of Columbia as a successful example of state/federal and private sector cooperation in investigating and prosecuting health care fraud; and
- 3) urges Congress to include in any health care reform legislation the authority to prosecute patient abuse and neglect of the elderly in health care facilities and in home health care programs at the state level; and
- 4) authorizes the Executive Director and General Counsel to transmit this resolution to the Administration, appropriate committees of Congress, and other interested individuals and associations.
- 5) directs NAAG to establish a subcommittee of the Health Care Task Force which would include representatives of the National Association of Medicaid Fraud Control Units to make recommendations for further action.

The CHAIRMAN. Thank you very much. I do have a few questions before I yield to Senator Cohen.

Tell me—and I am being very serious about this now, and I will start with you, Mr. Waterbury—what does the State legislature in Washington State do to support your efforts.

Mr. WATERBURY. I was going to be hard-pressed if you stopped right after “what do they do?”

The CHAIRMAN. Well, whatever they did before, they are likely not to do now for you being such a smart alec, I suspect.

Mr. WATERBURY. The State legislature in the State of Washington has actually been very supportive of the efforts of the attorney general's office in the area of health care fraud enforcement. That is not a classic answer, probably, that could be given to you nationally because there are some people that do the kind of work that I do that I have heard that their legislatures aren't as supportive.

But in direct answer to your question, they have always funded the Medicaid fraud control unit proposals at the 25-percent rate. If

we are going to talk about whether they would fund it at a higher rate or be more willing to, up to this point that has been the rate that they have had to do it.

The CHAIRMAN. Since there is an expenditure of State dollars, what is the rationale of why States don't do more? They have the authority to do more, if they wish, through the attorney general's office, whether it is Delaware, Indiana, Washington State.

I am truly trying to figure this out. I mean, we are constantly in the position, with limited resources, of trying to shift burdens from the county level to the State level, the State level to the city level, the city level to the Federal level. That just seems to me a statement of fact, a recognition of reality.

In my experience—and I may be mistaken; it may be too limited—the health care fraud units in the States, of the many States where they exist, have indicated to me they usually have difficulty convincing their State legislators and governors to invest more resources. There is not a limitation on what they can invest.

First of all, is that correct in incorrect?

Mr. WATERBURY. You are correct.

Ms. CARTER. I think it is much more complex than that. When the Medicaid fraud control units were originally instituted, they were focus on Medicaid issues and fraud. As the health care issue has become much more important and the public discourse much more extensive, people began at the State, I think, and I know at the Federal level, to look at how we can look at health care more broadly.

We find the funding, for example, is so convoluted and that State and Federal statutes are so specific that it makes it very difficult to have an effective and uniform and unified approach to health care investigations in combatting fraud and abuse at the local level.

For example, when I became Attorney General, once of the things that I wanted to do immediately, and did, was to meet with the variety of State agencies that oversee a host of State health care agencies and programs, and began to find out how we could work together in forming a kind of health care task force. We found that you could not use, for example, our Medicaid investigators or prosecutors or any of that, except solely for Medicaid fraud and control, even though we could have potentially used our partners or those individuals to do a variety of other activities.

The CHAIRMAN. Well, you know the reason for that, though. You know the reason for that?

Ms. CARTER. Yes, I do know the reason for it, and I think it is positive, but it also forms an impediment, a real impediment, to maximizing without unnecessarily duplicating activities.

The CHAIRMAN. You are right on point. Again, I don't have any brief on this. I am truly trying to figure this out. The same thing occurred in States that I am familiar with when they found out there was an inability to use federally-funded personnel to deal with matters that did not relate to federally-funded programs, which are many in my State, and I suspect in yours.

Instead of the governor, Democrat or Republican, saying, you know, we have got a real problem here in the State of Delaware or the State of Indiana or the State of Maine with State-funded

programs, why don't we go to the State legislature and ask the State legislature to fund for the Attorney General 2, 5, 7 more investigators to deal with this totally State-related issue—now, maybe I am mistaken, but I don't know many States that have done that in areas that are totally, completely, fully a local and State responsibility. That is my frustration.

Ms. CARTER. I think there have been an enormous number of States that have, in fact, not only discussions, but have been attempting to look at ways in which we can address that. But one of the other impediments is that we also know that there is a national health care reform debate and that whatever happens at the State level will be subsumed and superseded by whatever occurs here at the national level. So there is a sort of hurry up and wait kind of reality, so there is are lot of discussions.

I think there would be sufficient support, certainly, in Indiana by the governor and our legislators and others to move forward, but we find that we are also stymied not in a negative way, but in terms of trying to find out what is going to be imposed.

The CHAIRMAN. The only thing I want the record to reflect here, because it is a frustration for somebody like me who has worked 22 years of my life dealing with the criminal justice system at the Federal level—to use an expression of one of my colleagues, I am tired of wearing the jacket, as they say, by implication, that somehow we impede the ability of States to have better law enforcement capabilities, which is malarkey, flat malarkey.

There is nothing that stops a State, a governor or a legislature to deal with locally controlled senior citizen centers, locally controlled nursing homes, locally controlled, managed and licensed facilities, from going out and hiring 20, 10, 50, 500 more investigators. Instead, what we get, and the public believes it, is this notion that somehow the Federal Government, by implication at least, prevents this from happening. So, as you can tell, that is what you are sensing my resentment about, that maybe we should do more where there is a Federal nexus.

Ms. CARTER. I think that you are correct in the sense that if you have local problems and State problems, at some point local and State governmental entities must take care of those problems. But we can't ignore the fact that we have always had a partnership and we are interdependent, and so the same kind of argument—

The CHAIRMAN. Yes, but a partnership out of the largess of the Federal Government.

Ms. CARTER. Well, it is also a partnership because both the State and Federal Governments do things together and both benefit, and there can also be, in the best of all worlds, major benefits and contributions. At worst, it can be an impediment, and to the extent that it is duplicative, inefficient, poor communications, ill-funded all across the board, the bottom line is that the public suffers.

To the extent that we work together and understand that there is that interdependence and the necessity for that interdependence and partnership, which would include, in my mind, broad funding across the board, I think that we will do much better.

The CHAIRMAN. There is no question about broad funding. If we funded it all, it would be wonderful.

Ms. CARTER. Not just you. When I say broad, I mean Federal, State and local.

The CHAIRMAN. Good, OK.

Ms. CARTER. But I don't want the Federal Government to ignore the States either. I mean, I think there is a partnership.

The CHAIRMAN. We are about to pass a \$30 billion bill for law enforcement, all going to the States, all that money going to the States.

Ms. CARTER. Well, crime is local.

The CHAIRMAN. That is right, but the States aren't doing the job. You have a total population of 860,000 prisoners. You have a need for twice that amount. You, the States, are keeping people in jail 45 percent of the time for which you sentence them. We are about to fund \$10 billion to give to governors so they can build prisons to house State prisoners because they won't go to their State legislators and say the State is not doing the job. These are local offenses.

The Federal Government keeps their people in jail 85 percent of the time sentenced. The Federal Government tries people within 60 days of arrest. The Federal Government does that. As you can tell, I am tired of State governments coming to us and telling us this is a Federal responsibility. Ninety-six percent of the crime is local. Ninety-six percent of the fraud may be local. Now, I believe we should do a lot more, but I do believe it is important that States recognize and acknowledge the part the Federal Government does.

Ms. CARTER. With all due respect, I think that States do.

The CHAIRMAN. I have never heard a witness come and say, by the way, Senator, thank you for the Federal Government doing as much or more than my State has done for local problems in law enforcement.

Mr. WATERBURY. You know, I am, I guess, a law enforcement official in the State of Washington, and not just because of what you just said, but I do think the Federal Government has a leadership role in this area because, frankly, if you asked me whether we could have done this without you, the answer is no. It would have never been done. Health care fraud would not be a priority in law enforcement in my State if we had not developed the expertise, especially, frankly, in the patient abuse area, which is an area that really the public seems to grab on to and be very, very concerned about right now, but it is also in the area of fraudulent providers, et cetera.

Through the Federal leadership that has been shown 15 years ago that set up the Medicaid fraud control units and allowed the State of Washington to have one, I think that we have developed a law enforcement presence in our State and I think that the people in my State, including my boss, the Attorney General, would be the first ones to indicate that that is in large part due to Congress and the funding that we have had.

The CHAIRMAN. Let me tell you what is going to happen here, and you are both politically sophisticated in the best sense of that phrase. Do you know what is happening in the crime bill? Because federally-elected officials have to go home and stand for election for being the big spenders, the irresponsible people, which is a title we have earned, but reinforced by every State official that we run

across—because of that, you are probably not going to get your prison money. Do you know why? Because the Republicans are very angry.

Senator Gramm and others have a provision saying that you will not get one penny of Federal funding, general, until you keep your people in jail 85 percent of the time that they have been sentenced for. In your State, that means you will have to double your prison space or put up a sign in Indiana saying “no more crime in the year 1995.”

Unless you are way off the average, and you may be, the average is 43 percent of the time served. So assuming you are in the average, it means for the governor of your State to be able to apply for one single penny to build a new prison—Federal monies that I want to give them because we have a problem—in order to do that, you will go to the governor and say, governor, good news, there is a \$10 billion fund out there and we can compete for it. The bad news is that in order to compete to get one penny of that fund, you have got to go to the State legislature and double the number of prisons you have.

If you are keeping people in, on the average, 43 percent of the time and you have got to keep them in 85, you have got to literally double the number of cells. You have got to keep people who are sentenced to 10 years now serving $8\frac{1}{4}$ you have got to keep them in $8\frac{1}{2}$ years. This is what I get so angry with the States about because they are making people down here angry.

Literally, you are going to end up with no money because the governor of Indiana or Delaware—Delaware is small enough that they have truth in sentencing legislation already, so they would be an exception not because we are exceptional, but just literally we have a smaller problem. Literally, what is going to happen is no governor is going to ask for that money because they are going to have to go the legislature and say, by the way, we are going to have to spend 20 times as many dollars as we get.

So I had an idea. The idea was why don't we let the States just say they are going to make a good-faith effort. My Republican friends, represented by these able staff people here, and they are able, are going to say, along with a couple of my Democratic friends, no dice, Biden, truth in sentencing; unless they do it like we do it, they don't get anything, which means you are not going to get any money.

The Federal Government does a lot of things wrong, a lot of things, but one of the things we do relatively well is the law enforcement piece because we have a much smaller problem, only 4 percent of the problem. It all drops on your doorstep, not ours, so it is easier for us.

I am one who wants to increase your funding, Federal funding, to do the State things, but I really am concerned that because of this sort of animosity that has been built up that you are seeing reflected in the legislation now, we are going to lay it all back on you in a way that that partnership to deal with local problems—this has nothing to do with unfunded mandates. That is also another problem. We do that to you all the time, and we shouldn't. We should pay for what we mandate you to do.

But the end result of it all is that it really disturbs me that we are going to end up diminishing what needs to be done because we are blurring so totally the line of federalism here.

Ms. CARTER. I think the good news, however, is that in the health care fraud arena, because we have always had the partnership where the States have always carried their end of the bargain in terms of funding, personnel, investigations and prosecutions in conjunction and partnership and interdependent with the Federal Government, some of the issues that you have raised that are affecting the crime bill may not be as effective here in this—

The CHAIRMAN. Mark my words, general; mark my words. If 50 percent of the fraud is at a State level, you are going to have someone come and say let's fund 50 percent, not 90, not 80.

Ms. CARTER. Well, let me say two things. We want to make sure that we are at the table to have the dialogue, and that is why we commend you for having this dialogue on fraud. But we also know that States are able, willing, and already are paying their share and if we have to dicker over the percentages, at least we are still in the ball park and at least it is a formal recognition that the Federal Government understands that the State government is involved in this process and should remain involved in fighting fraud and abuse.

The CHAIRMAN. Well, after all of that, believe it or not, I am an ally, but I think you had better, with all due respect, get a slightly different hymnal from which you sing because you have got a lot of people up here who are feeling put upon. While we have capped spending for 5 years, this President has actually done something no one has done in 20 years, actually reduced the deficit 2 years running, and will reduce it a third year—real numbers, not phony baloney, makeshift numbers.

I think just as a piece of responsibility, I have never offered a program that I can think of where I haven't at the time I have offered it told the people of my State and the country how we pay for it. Sometimes I have said, like I did in the last crime bill, that we should increase the deficit; it is more important than the deficit. Last time, for health care, we should pay for these programs through a sin tax; I actually offered that when I offered the legislation.

This time, there is a trust fund for the crime bill, and there will be for some version of this, where we say here is how we are going to pay for it. I think that the public deserves that we tell them straight up how we are going to pay for these things. It is clearly in the public interest that every State do the job as well as—by the way, I am not being solicitous when I say this. Your reputations really do precede you. The reason why we invited you two here is because you two do the job, for real. You do the job, and the pay-back far exceeds any expenditure you make on behalf of the public. You are not the exception, but you are also not the rule.

I am anxious to work with you. As you know, general, from working with me on the crime bill, and your organization working with me on the crime bill, there is not a single thing I put in that crime bill that the Attorneys General didn't have a chance to comment on first.

Ms. CARTER. That is correct.

The CHAIRMAN. I think that is the first time that has ever happened, ever, and I feel the same way about this. Your experience, Mr. Waterbury, is real. You are a first-class professional; you are serious player. You know of what you speak, and that is why we asked you here.

One of the things, in addition to the funding piece, I want to ask you about—and the only reason I keep going is I think Senator Cohen had to go to another hearing—is to ask you about one piece of your recommendation, and that is that there be concurrent jurisdiction over Federal laws. I have been arguing against the Federal Government seeking jurisdiction over State laws; for example, the federalizing of all gun offenses.

The Attorneys General Association, and the DA's in particular, have been allies with me in that argument against that. You do the job very well, thank you, and we don't need to have an FBI agent and a Federal prosecutor doing the job. President Reagan once said, if it ain't broke, don't fix it. It is one of the few things I agree with him on. The Federal system ain't broke here. We have enough people servicing this and the fact of the matter is that if we load up what is now State jurisdiction on the Federal courts, we are not going to help you and we are going to break the Federal system.

But this is an unusual twist here and one that I am not opposed to, but I want you both to talk to me about it in this practical application. As I understand it, the National Association of Attorneys General, 29 of you, general, sent us a letter that proposed expanding Medicaid fraud control units so they can have concurrent enforcement authority over Federal laws, which is not something, again, I am opposed to, but something I understand—do you have a plane to catch?

Mr. WATERBURY. No. I am fine.

The CHAIRMAN. I thought you had to go because I know you—

Mr. WATERBURY. No. I was moving closer to her.

The CHAIRMAN. You guys can confer on this. Go ahead and do that because I am looking for—you know, either one of you can answer this, but this is a more unusual way of approaching it; that is that we don't often up here have State authorities, State prosecutors, saying to us, we want to be able to prosecute under Federal law in State courts. I am not opposed to that. I just want to make sure I fully understand it. Could you talk with me about that a little bit?

Mr. WATERBURY. Yes. First of all,

I would like to clarify something. What is called the sign-on letter that you referred to from the 29 AG's—

The CHAIRMAN. Yes.

Mr. WATERBURY. This is a general recommendation in the area of health care reform and authority. It is not a Medicaid fraud control unit proposal.

The CHAIRMAN. OK.

Mr. WATERBURY. It is more of a civil proposal in the sense of concurrent authority to do injunctive relief, since it has been discussed earlier by Mr. Stern, I believe, and to freeze assets.

The CHAIRMAN. I see.

Mr. WATERBURY. I would say as far as the criminal fraud enforcement, I am cross-designated in any number of States and dis-

tricts, and many of the personnel in the Medicaid fraud control units are. I believe Attorney General Carter indicated to me that she even offers the Federal prosecutors to become assistant attorneys general in her office and work in the Medicaid fraud control unit.

The CHAIRMAN. For the record, David, is it in State court they proceed or Federal court?

Mr. WATERBURY. No. This proposal, and I will let Attorney General Carter pick it up at this point, as I understand it, is for civil injunctive authority under Federal criminal statutes which would basically allow an assistant attorney general to come into Federal court and appear.

The CHAIRMAN. OK. Is that right, general?

Ms. CARTER. Yes.

The CHAIRMAN. OK. Now, tell me why you need that authority, or why that is preferable.

Ms. CARTER. It is a helpful practice for us, and the best examples we have are in the consumer protection area. With the Fair Credit Reporting Act, if they have a uniform law that is already on the books, we don't have to scurry to get State laws that are similar on the books. We can begin to continue to prosecute more quickly, so part of it is just practical realities that would preclude us from having to go for State legislative action.

The other area is that we have found in health care areas that there are so many times practically that if we already have the case and we have already developed the theory of prosecution, we usually just pull in a host of other people, and normally these same actors have committed a range of crimes. Then it is easier for us to just have them all in that package, and if we can have some concurrent authority it helps us to be able to prosecute more people.

The CHAIRMAN. Excuse me for the delay here. I have got to check, too, because I may have misunderstood something.

[Pause.]

The CHAIRMAN. The reason why I was delaying here was I was trying to find a copy of the letter sent to us.

Ms. CARTER. We have it. Do you want a copy?

The CHAIRMAN. I thought it said concurrent authority across the board, civil and criminal, to enforce civil and criminal sanctions. If that is not the case, then I—

Mr. WATERBURY. It is not, although it certainly is confusing because the one above it is Medicaid fraud criminal actions and the one below it is criminal actions. But this one is concurrent enforcement authority and it says, "The new civil penalties for health care fraud contained in several comprehensive health care fraud bills"—this would be the President's bill—"will enable prosecutors to pursue health care fraud that might not otherwise have been reachable." It is not clear, but they are talking in a civil context.

The CHAIRMAN. That is a useful clarification for us. Again, I don't have any brief for it one way or another. I just want to make sure I understand it. So, general, it would be useful if maybe you and I could—we don't have to do it now—get together on the telephone or get together later, after you talk to your colleagues, to make sure I understand—I think it is probably my misreading of the let-

ter, but that I understand precisely what it is that is being suggested or asked for.

Ms. CARTER. We would be happy to.

The CHAIRMAN. Again, I don't necessarily oppose it. I just don't fully understand it. I don't know what response we have gotten from the Justice Department about such a proposal, and so I want to make sure when I sit with them and have them at the table as well that I understand what we are trying to work out here so we don't end up with a more confused, rather than a clarifying and broadening of authority that allows there to be nonduplication.

You are probably sitting here thinking, well, with Biden as an ally, I am sure glad our enemies didn't show up at the hearing. I am just really concerned. Again, I keep coming back to this theme, and this doesn't relate to either one of you personally, and I mean that sincerely. I am really concerned that we don't tell the American people, those of us who hold public office—the average person makes no distinction between when I speak and when the governor speaks or when a Federal prosecutor or a State prosecutor speaks. They don't know from Adam. They shouldn't; I mean, they are busy just making their way. So there are very confused messages.

If you look at the polling data that is out there about law enforcement, people say they want more, but they get frustrated because they hear one message coming saying this outfit is not doing it and this outfit is, and they just simply don't know. I think that we who hold public office and stand for elective office have an obligation to go to people and say, look, everybody has got to do more.

By the way, the reason why I want to help the States—and I am going to be very presumptuous, but both of you are first-rate lawyers, beyond holding positions of holding positions of public responsibility. I am going to send you a copy of a speech I just made to the third circuit on a principled approach to federalism. I may not be right. I mean, I have spent a lot of time thinking about it and I would appreciate, not for the record, your feedback on it.

What I am worried about is, as the lines of federalism blur, not only do we find ourselves in a position where we may be moving perilously close to a position that is at odds with the constitution, but I think we blur the lines of responsibility.

My father has an expression. He says he wants to know who is responsible so he knows who to nail when it goes wrong. So whenever we would leave with four brothers and sisters, my father would turn and say, you are in charge, or you are in charge, or it is your job to feed the dog and yours to cut the grass, not, by the way, kids, I will be back in 6 hours; feed the dog, cut the grass, and while you are at it, would one of you run to the store for your mother and get some milk?

Then he would come back and he would say—I know this sounds corny and it is a little bit of a homily here, but he would come back and say, well, the dog is not—Val did it, or Joe did it, or whatever. It is very simple. I think that is what is happening in the criminal justice system, and I think that is why, although the people view it as the single most important thing they want us to do in government, they also increasingly doubt our ability to do it, even though we are doing a better job, “we” meaning you, me, the whole govern-

mental system. I think it goes to this issue about who is on first and who is on second in a time of limited resources.

Yes, general?

Ms. CARTER. I would like to invite you, Senator, to Indiana because I think you would in many ways be pleased with some of the discussions that are going on. With regard to just prisons, for example, we have built more prisons with State funds and we have expanded our facilities and we are in the process of reforming our juvenile justice system.

I don't know that you hear quite the hysteria and the finger-pointing on Capitol Hill that you might hear in a constant stream before you through these hearings. From my perspective in the hinterlands of Indiana, I think there is a pretty balanced discussion that is going on with regard to funding and responsibility and accountability, and I think that there is a sense of people that they are not happy with government. There is an enormous amount of cynicism and skepticism, but I don't think that it is disproportionately pointing the finger here or there, and I think that we do appreciate what you all do here.

The CHAIRMAN. I think there is a reason for that, General Carter, and that is because you—and you have one of the best governors in the Nation.

Ms. CARTER. Yes, we do.

The CHAIRMAN. You have a guy who is the governor—truly, one of the best in the whole country—who ran in a State that doesn't elect people of his party, generally, like you, and straight out told folks, here is the deal. He stood right up, as I recall it, and said, this is the deal, these are the costs, these are the expenditures, these are the problems; if you want me to do this, it is going to cost this, this is how it is. That is not the general rule among Senators, among Congresspersons, among governors, and I dare say maybe even among Attorneys General.

In the State of Delaware, we get a relatively high proportion, based on per capita distribution, of criminal justice monies; purely coincidental, I am sure, and I make no apologies for that. But do you know what I found out was happening in my little old State? We, the Federal Government, were sending money into the State to increase law enforcement capabilities. We have a little committee that meets to distribute these funds appointed by the governor and by the local folks.

The legislature figured out that, you know, this money we are getting in here for drug control and this money we are getting in here for more police, et cetera—here is what we do: we don't net-increase the number of anybody we have; what we do is we reduce the State funding for the public defender's office, the State funding for the attorney general's office and the State funding for the judicial system, and we supplant it with these Federal dollars that are coming in. So the end result is there is no net increase, or little increase, in the money that was supposed to go directly for more cops.

This time when I wrote the Biden crime bill, guess what? If you reduce by one single officer the number of police you have, you don't get a single penny out of that \$9 billion, not one penny, because the deal here is there are 547,000 police officers in America.

When my bill passes, and I hope it does, and is signed by the President, I want 647,000 police officers in America, not 550,000 with 100,000 funded by the Federal Government. That is the frustration folks like me feel.

There are notable exceptions. Governor Cuomo and Governor Richards are asking for—and I am sure there are a number of Republican governors, as well, going in and asking their State legislators for money for prisons, but that is more the exception than the rule. I just think we have to have a little truth in legislating and tell people what we are willing to pay for, who is paying for it, and how.

Again, the reason you two were invited here is because you two have reputations for doing that, and so I am anxious to work with your organization, as well as yours, Mr. Waterbury, and the other groups that exist in the other States. We need that practical input because the flip side is you know a lot better at a local level than we know at a Federal level how to deal with your problems at a local level.

Where there is a Federal nexus, and there is in this area of health care, and there will be a larger one, we should do our share, like we should on the drug stuff as well, which is what I am going to want to be talking to you in another month or so about, General Carter. We are going to spend about \$13.1 billion next year, which is 5 times the amount of money we are going to spend in the crime bill in the first year, on drug enforcement activities and drug treatment activities because that is a Federal problem. Drugs are porous; the drugs consumed in Indiana don't all originate in Indiana. They originate in the port of New York, they originate in Colombia, they originate in Seattle, where a lot of stuff is coming in, and also in Vancouver, in Canada.

So you could do the best job in the world and you can't do the job on drugs. So it makes a lot of sense for the Federal Government to play a larger role there, but it doesn't make any sense for the Federal Government to be paying for the enforcement of scoff laws in Seattle or Indianapolis. That is the kind of thing we have got to figure out.

Again, I am sorry to go off so much on this, but I am worried that this funding which is now there, and there is a desire for it federally, is going to be jeopardized if we don't figure out a way for everybody to step up to the ball.

Thank you very, very much.

Ms. CARTER. Thank you very much.

The CHAIRMAN. I look forward to continuing to work with you, and you both do a heck of a job. Thanks.

Mr. WATERBURY. Thank you.

The CHAIRMAN. Our last panel of witnesses is probably wondering why we had that discussion on federalism, or that lecture, as it turns out, by me. We have three distinguished persons. Our first witness is Kirk Johnson. Mr. Johnson is General Counsel for the AMA. The second witness is Kevin Mattessich. Mr. Mattessich is currently in private practice and was formerly a trial attorney in the Department of Justice Health Care Fraud Unit. Our final witness is Mr. William Mahon. Mr. Mahon is Executive Director of the

National Health Care Anti-Fraud Association, which includes many insurance companies as members.

Thank you for your patience and thank you for being here. I am not being solicitous when I say we are anxious to hear your views on this issue. Why don't we begin in the order in which you have been called? Mr. Johnson, welcome.

PANEL CONSISTING OF KIRK B. JOHNSON, GENERAL COUNSEL, AMERICAN MEDICAL ASSOCIATION; KEVIN M. MATTESSICH, MORRISON, MAHONEY AND MILLER, FORMER TRIAL ATTORNEY AND HEALTH CARE FRAUD PROSECUTOR, CRIMINAL DIVISION, U.S. DEPARTMENT OF JUSTICE; AND WILLIAM J. MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

STATEMENT OF KIRK B. JOHNSON

Mr. JOHNSON. Thank you, Chairman Biden. It is a privilege to be here. Thank you for asking for our testimony.

You were right. The AMA does officially support junkyard dogs, but as long as they are FBI agents.

Now, let me start by emphasizing the areas where we are in agreement with the comprehensive legislation of Senators Mitchell, Chafee, and the amendment by Senator Cohen. We do agree that fraud and abuse is a major problem in this country, and it is a disgrace to the entire profession when, as sometimes happens, physicians are involved. We have no interest in defending these doctors or making it any easier for them to get away with it. We want them caught.

More can and should be done. The Federal Government should have an expanded role. There should be more resources. So should physicians and their professional societies—more and better reporting by doctors and others who see the fraud as it develops, we think, and the FBI agrees with us, is really an important step in trying to do better.

We want the AMA and the profession to play a greater role in detecting and reporting fraud. Here is what we can do. We can get doctors to tell us about it. If they feel something will be done, if they feel the focus is on true fraud and not mistakes, if they feel they will be protected if there is litigation, they will report.

As you may know, we established an 800 hotline number with the FBI to report fraud. We have had over 100 calls in the last year. Many investigations have resulted from those reports. We are proud of that activity, and doctors just are disgusted by this stuff.

Now, let me be a little more specific about our position. As I said, we strongly support the central thrust of the Mitchell and Chafee bills. Given where we are in health care spending, given the abuses we have seen, it is obvious we need more resources to go into finding and preventing fraud, particularly if it involves doctors.

Physicians are made like the rest of us. They have human flaws, but their positions require them to act and behave differently. Overall, they have to be better citizens. They have to have higher standards, be less susceptible to self-interest, and certainly less to dishonesty. That have to be trusted. That is really the bedrock of our system. If you don't have the faith that when you see your doc-

tor he or she will put your interests first, we think the system of health care in this country collapses. So we are very interested in trying to do everything we can to find doctors who don't hold up that trust.

We are not asking for a medal, but the FBI will tell you that, in fact, of all the players in the health care system, doctors are the least likely to be involved in fraud. They are involved to some extent, but they are the least likely of all the players.

The CHAIRMAN. I agree with that, by the way.

Mr. JOHNSON. And that is from the FBI.

So how do we get the fraudulent, dishonest characters out? The AMA has thrown out about 100 doctors in the last 2 years. Our judicial council does it. Whenever there is a finding by a Medicaid fraud unit or by a medical society that someone is engaged in dishonest conduct, we kick those doctors out, and we have had about 100 go in the last 2 years.

We like the approach of the bills that give the Department of Justice, particularly through an expanded FBI corps—to do the health care fraud and to coordinate it. We think they need more authority. We believe the focus needs to be on fraud, not on mistakes, and we strongly endorse the inclusion of an intent standard in both bills.

We believe it should be a Federal crime to defraud either the Federal Government in a Federal program under Medicaid or Medicare or other programs, or a health care plan even if it operates exclusively in the private sector. We support that expansion of Federal regulation to that extent.

Now, here is where we express caution. First, we believe the FBI, not the IG of HHS, should lead that initiative. The HHS inspectors are dedicated and hard-working. We did meet with June Gibbs Brown just 2 weeks ago to talk about the IG. We have confidence in her, but the private sector is not Medicare and Medicaid. There will be more and more for HHS to do under Medicare and Medicaid. They are not staffed to do it today.

The FBI has the experience in private sector criminal actions. We think they have the resources. They have devoted over 200 more FBI agents within the last few years, you have heard today. They do need more resources, but we would put our faith in Justice and the FBI, and that manpower, that training and that experience. We have worked with them closely. They should guide, create and lead that effort.

Second, we would not at this time extend the new Federal fraud initiatives to purely civil actions and civil sanctions, at least to the extent that the IG involved. Civil actions in the private sector will involve disputes short of fraud, short of clear and deliberate efforts to cheat a program—not the kinds of things that Senator Cohen discussed today and you, Chairman Biden, have talked about. These will be disputes about billing, about coverage, about procedures, about quality, about coding, about a whole list of things.

There are over 1,200 insurance plans or other kinds of plans in this country. Each has a different set of rules for all of these various facets of medical care delivery. It would be a huge and daunting and complex task for HHS or anyone to take on that burden, given where it fits in total health care spending.

It is the real fraud, it is the dangerously bad care that we should put our limited resources at, and we should increase those resources. It is not only a complex area for HHS to get into, but it is one that is being addressed by payers with increasing vigor and effectiveness. The socialization of crime that Senator Cohen talked about is ending. The attitudes are changing.

Most medical procedures in the private sector today are reimbursed by insurance companies or a self-insured employer or a group of employers. The patient generally doesn't pay the bulk of the bill. The way these payers approach costs today, particularly unnecessary costs or abuses, has changed dramatically as the health care system itself has changed. Cutting costs is their primary goal. It is a highly competitive business based on price.

The physicians that are in these plans are generally subject to profiling, in which their procedures, their referrals and the kind of care they provide is monitored, recorded and measured. Any suspicion of overutilization, not to mention abuse, gets you thrown out of the plan. Since the plan has your patients' lives at stake, the consequences are very serious.

We don't think that Cigna, Aetna, AT&T, those people who are paying for health care today and have changed their approach to how they look at costs and how they look at abuses—they won't accept it any longer. We don't think they need the help of HHS and the private sector. Those kinds of disputes are disputes that good businessmen and women are going to take care of. So we can't support at this time the extension, at least with regard to HHS authority, into the private sector. We can't, in good conscience, support it because physicians are telling their children today, don't go into medicine, there are too many hassles.

Another group of Federal bureaucrats in these kinds of nonfraud areas hassling, second-guessing and watching over doctors is not good for the profession, and they are going to bump into the others who are doing it in a more and more sophisticated way each day with their computer software programs.

Another massive change in health care, and we talked about it today, is, of course, managed care. That is capitation. When physicians are at financial risk for the care they provide, the kinds of incentives to overutilize, of course, disappear. Now, there are other problems that we have heard about today from David Waterbury with regard to managed care and capitation, and those problems do need to be looked at. They are not necessarily fraud problems.

It is very hard to make judgments with regard to whether a physician, because he is incentivized, is providing too little care. It is very easy when there has been a double billing, where there has been a scheme to create paperwork that gets paid for somewhere down the road. These kinds of things need to be dealt with in other ways. The AMA has a patient protection act which would help. We also think antitrust relief, Chairman Biden, would be of great benefit so that some of the competing plans out there, at least some of them, are physician-directed plans with physician values and physician utilization review. Today, we are impeded in doing that.

The final point I want to make about physicians and the crime bill, to the extent it extends HHS into nonfraud areas, into civil areas in this huge, vast private sector—physicians are the most

regulated sector of the economy today. Whether it is CLIA or OSHA or RBRBS or all the rules in the private sector, the list is endless. There are 80 new regulations a year that come out from HCFA, over 500 pages full of Federal Register.

I am here today talking to you. We always send a physician trustee. Physician trustees of the AMA don't feel comfortable because they don't understand fraud and abuse. It is too damned complicated. I don't feel comfortable with all the rules and regulations we have to deal with today, and every now and then a very good doctor gets caught. Usually, they are in the inner city doing Medicaid or they are in rural areas where they don't have the expertise to understand which rule they have to comply with, and sometimes they actually go to jail. So we have to keep that doctor in mind as well.

The bottom line here, Chairman, is that we support an increased Federal effort. We support making fraud in health care a Federal crime. We support giving the FBI a coordinating role. We support additional resources, and we ask to be able to work with the FBI, or whomever, so that physicians can detect fraud and report it and eliminate that part of the waste from our system.

Thank you very much.

[Mr. Johnson submitted the following materials:]

PREPARED STATEMENT OF KIRK B. JOHNSON, JD ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and Members of the Committee: My name is Kirk B. Johnson, JD. I am the General Counsel of the American Medical Association (AMA). Accompanying me is Hilary Lewis, JD, of the Association's Division of Federal Legislation. On behalf of the AMA, I want to express our appreciation for the opportunity to provide our views on the subject of health care fraud and abuse, particularly within the context of health system reform.

As the nation awaits the emerging changes in health care delivery under any reform model that is ultimately adopted, you are confronted with the challenge of eliminating a very serious problem that consumes vast economic resources, and, more importantly, threatens the health and safety of our patients. The fraudulent and abusive schemes that, unfortunately, have entered our health care system often lead to the rendering of medically unethical or potentially harmful testing, as well as inaccurate, misleading, and false diagnoses. As a consequence, such practices undermine health care delivery, and also bear future patient and societal ramifications by generating unnecessary fear, jeopardizing the ability to obtain universal health care coverage in the future, and increasing the already high cost of health care.

While the scope of illegal activity under analysis today is clearly substantial, its precise dimensions remain difficult to quantify. One point, however, must be emphasized: Whatever resources are expended for fraudulent and wasteful practices divert the use of funds and efforts from meeting legitimate health care needs. The AMA urges the creation of programs to identify and eliminate abusive, wasteful and fraudulent practices.

Mr. Chairman, the AMA was pleased to work with you in the 102nd Congress in formulating rational solutions to this complex problem. Once again, we commend you for recognizing that the elimination of fraud and abuse is integral to our nation's ability to reduce the rate of growth in health care spending.

COST OF HEALTH CARE FRAUD

In order to effectively address the issue of health care fraud, its proportions and magnitude must be accurately identified. The AMA believes that more rigorous scrutiny must be brought to bear regarding the existing nature and amount of health care fraud. Only careful examination of its scope will yield the most effective solutions to this difficult problem. Reports presented to date are speculative and are not based on credible data or evidence. Further information is needed.

In an effort to identify areas of fraudulent practice, the AMA would be pleased to work with the federal government in studying the extent to which health care

fraud permeates the current environment. Our own survey data, for example, have elicited valuable information on the incidence of hospitals that require physicians to make payments for hospital services. In our study, physicians were asked: (1) Whether any hospital had ever requested the physician (or the physician's practice) to make payments to the hospital for the privilege of serving its patients; and (2) whether the physician had ever been asked to make unreasonable payments to a hospital for the privilege of utilizing space, supplies, equipment, utilities, hospital employees, or billing information. (See Attachment A.) In our view, the proper compilation of similar data on other possible abuses pervading our health care system will aid in the development of the most effective solutions to identified problems.

We strongly concur with the recommendation issued by the General Accounting Office (GAO) in a May 1992 study that calls for the establishment of a national commission to develop comprehensive solutions to fraud and abuse in the provision of health care. We also support the recommendation in the December 1992 GAO study advocating a nationally coordinated effort to combat such fraud and abuse.

HEALTH CARE FRAUD AND PARENT CARE

The high economic costs associated with fraudulent conduct obviously siphon off valuable dollars that could be more effectively utilized in providing universal health care coverage to our citizens. Perhaps the most injurious and alarming aspect of this illegal activity involves the victimization of patients—a truly lamentable consequence of the devious tactics perpetrated by these mercenary entrepreneurs.

For example, in the California Rolling Labs case, patients were solicited to undergo medical examinations and laboratory testing, lured by the attendant promise that insurance reimbursement would be accepted as payment in full, and co-payment would be waived. Out-of-pocket payments, however, were often required prior to the exam as a show of "good faith." In many instances, patients were subjected to medically unnecessary, unethical, or potentially harmful testing. Reports of cardiac stress tests administered without the presence of a defibrillator were a common occurrence. False diagnoses given in the course of such exams, moreover, threatened improper treatment, prompted unnecessary fear, and resulted in the compilation of erroneous medical records that could follow patients attempting to apply for health insurance in the future.

Superfluous expenses also are generated by these fraudulent schemes as patients may undergo repeated testing by their regular physicians in order to obtain a second opinion. Ultimately, the cost of these fraudulent claims, moreover, is borne by all consumers. The investigation of the California Rolling Labs revealed that more than \$1 billion worth of fraudulent claims were filed. While the owners were both sued and prosecuted successfully, virtually no monies have yet been recovered.

Other cases in which ignominious activities in various sectors of the industry have imperiled patient care involve reports of individuals detained in mental health facilities far beyond the time necessary for appropriate care and treatment. A familiar scenario involves a facility that becomes cognizant of a patient's extensive health insurance coverage. When so apprised, the institution then prescribes a lengthy inpatient stay as a matter of course. The ensuing bounty of third-party reimbursement generated from additional inpatient days accrues to the benefit of hospital revenue. Sadly, patients in need of mental health services may be particularly vulnerable to such intolerable practices, inasmuch as communications between the patient and the outside world are easily curtailed under these circumstances. Patients have been forced to remain institutionalized, subjugated to the sinister profit motive of these facilities and unable to secure timely release through family or friends.

LEGISLATIVE APPROACHES

The AMA deplores the very real problem of fraud and abuse perpetrated by criminal elements and believes that all reasonable efforts must be used to combat such crimes. We applaud the Committee for examining the critical issue of health care fraud and abuse today. In fact, every major health system reform proposal introduced in the 103rd Congress would act aggressively to reduce or eliminate this severe problem.

1. S. 1757—THE "HEALTH SECURITY ACT"

S. 1757, the "Health Security Act," introduced by Senator George Mitchell (R-ME), would establish an all-payer health care fraud and abuse control program, with joint authority over the program granted to the Department of Health and Human Services (HHS) through the Inspector General (IG), and the Department of Justice (DOJ) through the Attorney General. These departments would be statu-

torily mandated to coordinate efforts to prevent, detect, and control health care fraud and abuse. The program would conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care, and facilitate the enforcement of statutes applicable to these offenses.

An "All-Payer Health Care Fraud and Abuse Control Account," to be created in the U.S. Treasury, would be comprised of gifts and bequests made to the account. The account would also be financed through funds collected from all criminal fines imposed in cases involving a federal health care offense, other civil penalties, and amounts resulting from property forfeiture by reason of such an offense. Data sharing would be required between representatives of federal, state, and local law enforcement agencies, state Medicaid fraud control units, state licensure bodies, and representatives of health alliances and health plans.

Mandatory exclusion from participation in any applicable health plan for those individuals or entities convicted of health care-related crimes or patient abuse for a minimum period of five years would be imposed. Permissive exclusion from plans for a minimum period of three years would apply to convictions under federal or state law in connection with the delivery of a health care item or service, or acts or omissions involving government-operated programs. Actions subject to penalty with respect to an applicable health plan may be fined \$50,000 for each violation.

The "Health Security Act" defines "health care fraud" to include acts by one who *knowingly* executes or attempts to execute a scheme or artifice to defraud any health alliance, plan or individual in connection with the delivery of or payment for health care benefits, items, or services, or to obtain by means of false or fraudulent pretenses or representations any of the money or property owned by or under the custody or control of a health alliance in connection with the delivery of or payment for health care benefits, items, or services. A fine will be levied and/or a ten-year term of imprisonment will follow such a conviction. If the violation results in serious bodily injury, imprisonment for life or a term of years would ensue.

Finally, all self-referral by physicians to an entity in which they hold an investment interest would be prohibited. However, exceptions would be established for items or services paid for on an at-risk basis to a specific provider, such as capitated payments, physician recruitment to a rural area, discounts or other reductions in price between a physician and an entity, coinsurance under limited circumstances, and home infusion therapy. Civil monetary penalties would apply to the offering of inducements to individuals under health plans, to submission of a claim for an "upcoded" item or service, and to restrictions on the utilization of services under a service contract or health plan. A three-year minimum period of exclusion from Medicare and Medicaid would result. This penalty would also apply to individuals who default on health education loan or scholarship obligations, or who possess an ownership or control interest of 5 percent or more in a sanctioned entity. Culpable parties would be excluded from participation in all health plans.

2. S. 1770—THE "HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993"

S. 1770, the "Health Equity and Access Reform Today Act of 1993," sponsored by Senator John Chafee (R-RI), contains a number of provisions similar to those outlined above in the "Health Security Act." This proposal also would establish an all-payer fraud and abuse control program within the Department of Health and Human Services to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care. The HHS IG would be responsible for coordination of federal, state, and local law enforcement programs to control fraud and abuse. Similar to S. 1757, the program would be financed by an "Anti-Fraud and Abuse Trust Fund" consisting of monies from penalties, fines, and damages. It, too, would extend civil monetary penalties to the private sector.

Further, the "Health Equity and Access Reform Today Act of 1993" would amend the Medicare law to mandate exclusion of providers convicted of felonies relating to fraud or controlled substances from participation in Medicare and state health care programs. Permissive exclusion would be imposed upon individuals with ownership or control interest in sanctioned entities. Civil monetary penalties of \$10,000, and treble damages for each offense, would be levied against those who offer inducements to persons enrolled under or employed by federal or state health care programs or plans, and also against excluded individuals retaining an ownership or control interest in a participating entity.

In addition, the Secretary of HHS would be directed to establish a health care fraud and abuse data collection program to report, on a monthly basis, final adverse actions against health care providers. Confidentiality mechanisms to protect the identity of patients receiving health care services would be incorporated in the data collection program. Access to the health care fraud and abuse database would be

made available to the public, federal and state governmental agencies, and health care plans. The Secretary will publish all final adverse actions in the *Federal Register* on a quarterly basis.

A definition of "health care fraud" similar to that contained in the "Health Security Act" is also included in S. 1770. The bill calls for a fine, and/or a maximum 10-year prison sentence, against those convicted of health care fraud. Where health care fraud leads to serious bodily injury, the offender would be sentenced to life imprisonment. Finally, individuals convicted of federal health care offenses that pose a serious threat to the health of another, or that have a significant detrimental impact on the health care system, would be ordered to forfeit property used in the commission of the offense, or derived from proceeds traceable thereto, and that are of a value proportionate to the seriousness of the offense.

3. THE "NATIONAL HEALTH CARE ANTI-FRAUD AND ABUSE ACT OF 1993"

Title XXXVIII of the crime bill, the "National Health Care Anti-Fraud and Abuse Act of 1993," introduced by Senator William Cohen (R-ME), would create enhanced penalties for anti-fraud enforcement efforts. Its definition of "health care fraud" is identical to those in S. 1757 and S. 1770. It also provides a real and personal property forfeiture penalty for any individual convicted of a federal health care offense.

4. FRAUD AND ABUSE PROVISIONS: THE AMA VIEW

The AMA commends the Administration and the Congress for providing a number of constructive approaches to the problem of fraud and abuse. In our view, any legislative solution that is formulated to address this issue must contain a number of critical elements.

a. Information and jurisdictional authority

At the outset, a comprehensive program designed to root out fraud and abuse must begin with the establishment of an intergovernmental commission to investigate the nature, magnitude and costs of this pervasive problem. The AMA recommends modification of current legislative proposals to include the creation of a clearinghouse, incorporating standards for the protection of confidential information, that could be utilized to detect fraudulent activity. All health insurance plans should then be required to provide information essential to fraud investigations, knowing that the confidential nature of this data will be ensured.

In establishing an all-payer health care fraud and abuse program, both S. 1757 and S. 1770 would undertake a comprehensive effort to grapple with the problem. We applaud these initiatives to combat fraud and abuse on a systemwide basis in both the public and private sector. However, the operational structure envisioned for such a program raises a number of concerns. Under the "Health Security Act," authority for its implementation and enforcement of this program resides with both the Department of Health and Human Services and the Department of Justice, through the exercise of broad authority to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care. In the "Health Equity and Access Reform Today Act of 1993," no specific role has even been assigned to the DOJ.

The AMA strongly urges that coordination of federal anti-fraud activities be delegated to the Attorney General, rather than the HHS Inspector General. The Department of Justice, especially the Federal Bureau of Investigation (FBI), possesses unique and demonstrated experience in orchestrating the law enforcement efforts of various federal, state, and local agencies. For example, the Chicago office of the FBI stands as a model of coordinated activity in which the HHS Inspector General, the state Medicaid fraud control units, private insurers, law enforcement agencies and other groups work together in a constructive and participatory effort. The Health and Human Services IG, on the other hand, has operated only in the coordination of fraud relating to federal programs. It has no historical jurisdiction over private plans. It is our firm conviction that success of the all-payer fraud and abuse control program contemplated in S. 1757 is contingent upon empowering the governmental agency with the greatest breadth of experience in law enforcement to take the leading role in the investigation and detection of fraud in the private and public sector.

In addition, the offices of the Inspector General in the Department of Labor, the Veterans Administration, and the Department of Defense have been cited as potential contributors to a coordinated law enforcement program. While the expertise of these agencies may be deployed to serve a highly useful role in this area, the AMA recommends that the predominant responsibility for coordination should be reposed in the Attorney General. Creation of a diffuse governing structure, employing a myriad of investigative and procedural techniques, would be fraught with inefficiencies

and ultimately ineffective. Clearly, the agency with the widest experience should be charged with management of this complicated activity in order to achieve coherent and unified objectives, and to ensure that all cases are pursued according to consistent standards, with fairness to the individuals or entities that are subjects or targets of an investigation.

Finally, S. 1757 and S. 1770 would permit investigations by mandating that the fraud and abuse control program could, without limitation, direct inspections relating to the delivery of and payment for health care. The AMA urges that the authority to conduct criminal investigations or audit functions be narrowly circumscribed, such that jurisdiction is restricted exclusively to the scrutiny and pursuit of anti-fraud matters.

b. Financing

The financing mechanism for the All-Payer Fraud and Abuse Control Programs established in the bills sponsored by Senators Mitchell and Chafee would come from a trust fund account consisting primarily of fines, penalties, and damages collected pursuant to convictions for federal health care offenses. The AMA strongly opposes the funding of a governmental program through penalties levied in connection with violations that the activity is designed to eliminate. We believe that such a bounty system provides inappropriate disincentives for the objective implementation of the program. We, therefore, recommend that financing of this effort be secured through general revenue or another appropriate financing source.

c. Definition of "Health Care Fraud"

The AMA commends the measures being reviewed at this hearing in articulating specific definitions of a "federal health care offense" and "health care fraud." Health care fraud and abuse is currently prosecuted under sections 1341 and 1343, Title 18, United States Code, the mail and wire fraud statute, as well as under Title 42, Medicare. These two provisions must be reconciled in any legislative proposal in order to: (1) attain consistency; (2) preclude harsh sanctions for inadvertent or legitimate mistakes, such as billing errors; and (3) impose penalties commensurate with the offense committed. We are pleased that S. 1757, S. 1770, and the Title XXXVIII provisions in the crime bill articulate clear definitions of what is proscribed.

The AMA believes that a physician is, of course, responsible for actions performed in his or her name. Yet the physician should be found to be acting with the *intent* to commit a fraudulent act where a court imposes a severe sanction. The previously cited definitions set forth in the proposals under consideration properly incorporate a standard of knowledge on the part of the defendant that requires the demonstration of an intent to commit fraud. This standard would also reduce the possibility that honest mistakes lacking in criminal intent, such as inadvertent billing errors, are not pursued according to the dictates of criminal law and procedure.

d. Penalties

The "Health Security Act" and the "Health Equity and Access Reform Today Act of 1993" call for criminal penalties for all payers, for acts involving Medicare or state health care programs, such as willful submission of false information or claims, and acceptance of kickbacks, bribes, or rebates in return for referral for services. The AMA supports all appropriate sanctions for acts of this nature.

Other penalty provisions in these bills range from a mandatory exclusion from participation in any applicable health plan for those individuals or entities convicted of health care-related crimes or patient abuse, for a minimum period of five years, as well as mandatory exclusion of providers convicted of felonies relating to fraud or controlled substances. Permissive exclusions would apply to an individual or entity convicted under federal or state law in connection with the delivery of a health care item or service, or any act or omission in a government-operated program.

We recommend the application of exclusion procedures to all payers *only* for criminal convictions, with exceptions recognized for rural or urban underserved areas, inasmuch as exclusion from provider participation in these communities would impact deleteriously on access to health care.

In addition, the Secretary of Health and Human Services should not be authorized to exclude health care professionals or providers from private plans unless a criminal conviction has been obtained, or an immediate and grave risk of patient harm would result from a provider's continued ability to deliver medical or health care services under the plan. Adoption of these standards would preclude the possibility of eliminating one's livelihood for an unintentional failure to comply with Medicare and Medicaid regulations, such as may occur when billing errors arise. Opportunities for administrative review of exclusion determinations must also be guaranteed.

The "Health Security Act," the "Health Equity and Access Reform Today Act of 1993," and the "National Health Care Anti-Fraud and Abuse Act of 1993" also call

for forfeiture of proceeds obtained through the commission of a federal health care offense posing a serious threat to the health of any person or having a significant detrimental impact on the health care system. While forfeiture of direct proceeds represents a reasonable penalty, the AMA opposes a RICO-type confiscation procedure employed in the health care arena.

The AMA notes the severity of the criminal penalties contained in these measures. Although the bill seeks to reduce the number of criminal actions that occur, such sanctions must be meted out in a fair and equitable manner so that improper conduct is penalized commensurately with the crime. In this regard, the case of Carol Sims Robertson, MD stands as a vivid example. Dr. Robertson is serving 12 years in prison for inappropriately signing Tylenol 3 prescriptions in an inner city clinic in Detroit. (See Attachment B.)

With respect to civil monetary penalties, S. 1757 and S. 1770 would expand the authority of the HHS Inspector General to impose sanctions in this area as well. The levying of civil monetary fines is based upon a lower standard of proof than criminal sanctions. Therefore, we believe that the purview of the Inspector General's authority should not be extended to private health benefit plans whose activities would be subject to control by the federal government. The AMA strongly opposes expansion of IG jurisdiction in this regard.

e. Physician ownership and self-referral

As health system reform and integrated entities evolve over the next several years, the practice of self-referral will greatly diminish, or will be subsumed by integrated or other delivery systems for genuine efficiency purposes in order to compete on cost and quality. With the modification of fee-for-service arrangements, self-referral concerns will become peripheral. In this new health care environment, physicians will be unable to control where their patients acquire ancillary health care services. That decision will be made by the managed care entity.

Although we support the Administration's effort to prohibit self-referral, additional modifications are necessary. The AMA agrees in principle that physicians should not refer patients to a health care entity outside of their office practice at which they do not directly provide or supervise care or services when they have an investment interest in the facility or service. However, the current "self-referral" limitations, even as applied to Medicare and Medicaid, are far too restrictive.

The AMA is opposed to current legislative proposals that would further restrict the ability of physicians and group practices to provide necessary medical care to their patients. These restrictions would constitute an unwarranted federal intrusion into the practice of medicine. As outlined below, our ethical policy recognizes that an exception to this prohibition must be created where there is a demonstrated need in the community for the facility, and alternative financing is not available. Furthermore, in those instances where there may be an ownership interest and referral permitted (such as in rural and inner city areas), the legislation must be modified to safeguard the patient. In these cases, physicians and others minimally should comply with well-established ethical requirements regarding the marketing efforts of the facility or service, return on investment, noncompetition clauses, patient disclosure, and utilization review.

An exception to address community needs would be clearly justified, especially when physician ownership may create a facility that would not otherwise exist to serve local residents. Patient benefit and patient access to health care facilities always must remain the paramount concern.

Other matters that must be addressed include:

- The "shared" facility issue. The AMA supports such an exception for situations in which physicians share facilities (such as laboratories) outside of a formal group practice arrangement.
- An exception for community need as explained in the AMA's ethical opinion outlined below.
- A clear exception that would allow nephrologists to provide dialysis services to their own patients, as well as to hospitals and to hospitalized patients, on an in- and outpatient basis. The exception contained in the 1993 Omnibus Budget Reconciliation Act (OBRA '93) does not specifically allow a continuation of this practice in the manner that assures continuity of care for dialysis patients.

f. Kickbacks and safe harbors/hospital acquisition of physician practices

Another area of concern involves illegal kickbacks. Clearly, acceptance of kickbacks, bribes, or rebates in return for referral for services should constitute a criminal violation and be punished accordingly. Illegal kickbacks also occur in cases where hospital contracts with physicians call for payments on terms other than fair

market value. As physicians wish to comply with all legal requirements in business transactions, it is, therefore, imperative that the legitimate parameters of these arrangements be specifically defined. Distinctions must be made between agreements that induce physicians to inappropriately refer patients, or order unnecessary items or services, and those that do reflect reasonable business practices.

The AMA believes that an improper inducement would exist where: (1) Incentives are paid on a per-referral basis; (2) incentives are offered only to so-called preferred "heavy admitters"; (3) incentives are paid above fair market value, or when little or no substantive services are provided; (4) free or discounted leasing space or services are offered; (5) discounted continuing medical education is offered only for the purpose of enhancing private practice earnings; and (6) unreasonable upfront payments in the sale of a medical practice are offered for such factors as good will and patient lists.

However, safe harbors must be delineated to protect legitimate practices that may involve remuneration between parties, yet may still be construed as an arm's length business transaction. Some recruitment and retention plans in fact provide benefits to both patients and providers. For example, incentives granted to physicians to practice in underserved areas, secretarial support and computer access to facilitate the performance of medical staff duties, discounted continuing medical education improving the institutional ability to monitor quality of care, and purchase of the sole medical practice in the community should all be legally permissible. In order to condemn a business arrangement as an illegal kickback, moreover, intent to provide referral in return for other perquisites must be established. The AMA recommends action to ensure that all assets of a physician's practice, both tangible and intangible, can and should be used to determine the market value of the practice.

g. Reporting

S. 1770 would establish a health care fraud and abuse data collection program to report final adverse actions against health care providers, suppliers, or practitioners. The information reported to the HHS Secretary would include: (1) the name of the provider, supplier or practitioner; (2) the name of any health care entity with which a provider, supplier, or practitioner is affiliated; (3) the nature of the final adverse action; and (4) a description of the acts or omissions and injuries upon which the final action is based. Access to the database would be made available to the public and to governmental agencies.

The AMA opposes the creation of a national database containing fraud and abuse information. If any such database is constructed, appropriate safeguards for the confidentiality and use of the information contained therein must be included. S. 1770 addresses the issue of confidential patient information, but fails to consider critical matters regarding confidentiality and privacy of the reported subject. We also urge that the term, "final adverse action," be more carefully circumscribed so that cases pending on appeal are not identified as final. The bill's current definition only would preclude the reporting of settlements where no finding of liability has been determined without delineating any parameters for control of database information.

ETHICAL ISSUES

1. REPORTING

When a physician provides care in a fraudulent manner, numerous ethical breaches occur. The AMA has addressed these matters through various ethical pronouncements. For example, ethical physicians must accept the responsibility to report colleagues who are engaged in fraud or deception. The AMA Principles of Medical Ethics state as follows:

A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

Opinion 9.031 of the AMA's Council on Ethical and Judicial Affairs (CEJA) outlines the physician's obligation to report impaired, incompetent, and unethical colleagues in accordance with the legal requirements in each state pursuant to the guidelines outlined in the opinion. With respect to the reporting of unethical conduct, the opinion specifically states:

Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service. Unethical behavior that violates state licensing provisions should be reported to the state licensing board. Unethical conduct that violates criminal statutes

must be reported to the appropriate law enforcement authorities. All other unethical conduct should be reported to the local or state medical society. Where the inappropriate behavior of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Anonymous reports should receive appropriate review and confidential investigation.

2. PHYSICIAN OWNERSHIP OF MEDICAL FACILITIES AND SELF-REFERRAL

The AMA Council on Ethical and Judicial Affairs undertook an intensive examination of the issue of physician ownership of medical facilities and the ethical issues presented by "self-referral" of the physicians' patients to these facilities. In brief, the AMA believes that when adequate alternative facilities exist, self-referral is presumptively inconsistent with physicians' fiduciary duty to their patients. However, where there is demonstrated community need for a facility and alternative financing is unavailable, self-referral is appropriate and even necessary. Moreover, physicians must be free to invest in ancillary facilities, such as ambulatory surgical centers, in which they personally provide care to their patients. For physicians, the highest priority must always be the needs of our patients.

The AMA strongly recommends that physicians should not refer patients to a health care facility outside their office practice (or their group) at which they do not directly provide or supervise care or services when they have an investment interest in the facility. If there is a demonstrated need in the community for the facility and alternative financing is not available, however, referral should be permitted. If this exception is met, the physician must comply with further ethical requirements relating to the marketing efforts of the facility, referral requirements, return on investment, noncompetition clauses, disclosure to patients and utilization review.

Through CEJA Report C (Attachment C), the AMA established strict formal guidelines for those physicians who, in order to serve their patients, invest in outside facilities and refer to those facilities. The physician *also* must comply with the following further ethical requirements:

- a) Individuals who are not in a position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment is offered to physicians must not be related to the past or expected volume of referrals or other business from the physicians.
- b) There is no requirement that any physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor.
- c) The entity must not market or furnish its items or services to referring physician investors differently than to other investors.
- d) The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.
- e) The return on the physician's investment must be tied to the physician's equity in the facility rather than to the volume of referrals.
- f) Investment contracts should not include "noncompetition clauses" that prevent physicians from investing in other facilities.
- g) Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities if any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that they will not be treated differently by the physicians if they do not choose the physician-owned facility. These disclosure requirements also apply to physician investors who directly provide care or services for their patients in facilities outside their office practice.
- h) The physician's ownership interest should be disclosed, when requested, to third-party payers.
- i) An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

- j) When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.

Report C is based on a number of observations. It recognizes that there are circumstances under which patients may be deprived of the best health care if a physician cannot refer patients to a facility in which the physician has an investment interest. Physicians have often been exclusively motivated by the important needs of their patients in becoming involved in such arrangements. Clearly, blanket bans on self-referral are inappropriate. Also, investing and referring, when it is a direct extension of a physician's commitment to serve patients' needs, is both ethical and desirable. This recognizes, however, that those needs must not be marginal or rationalized needs, or secondary to a profit motive. Non-physician or non-referring physician investment for developing ancillary health care facilities and services should be explored and exhausted.

AMA INITIATIVES AND RECOMMENDATIONS

The AMA recognizes that additional efforts must be undertaken to confront health care fraud and abuse, especially inasmuch as it transcends the medical profession, reaching into many segments of our society. Unfortunately, people and entities from all walks of life have been found culpable in contributing to the magnitude of the problem.

The medical profession remains committed to rendering high quality medical care to its patients on an ongoing basis, and the AMA is proud of the work of our professional community. While some physicians have been implicated in health care fraud activities, we note that their numbers have been minimal. Even this slight level of physician participation is unacceptable, and the AMA does not condone fraudulent activity on the part of even one individual. In a profession that relies on public and individual patient trust as a vital element in providing successful medical care, any number of "bad apples" is too many.

The AMA stands ready to assume an active role in identifying those who would profit by improper use of their authority to practice medicine. We pledge to continue working with the Congress and appropriate law enforcement agencies in a cooperative endeavor to attain the goal of eliminating health care fraud in all of its forms. To this end, the AMA is pursuing a number of activities.

1. COOPERATION WITH FEDERAL BUREAU OF INVESTIGATION (FBI)

Since 1992, the AMA has worked with the Federal Bureau of Investigation to confront issues relative to fraud and abuse. FBI representatives have expressed to us that physicians are *not* responsible for the vast majority of health care fraud and abuse. The AMA, however, does not take comfort from the fact that only a small number of physicians seek to gain through fraudulent practices.

We have been pleased to provide assistance to the Bureau in a cooperative endeavor as it attempts to identify and prosecute health care fraud. AMA officials have participated in sessions in which the FBI trained agents to ferret out fraud. We have also offered our network of state and specialty societies, boards and other entities to combat criminally fraudulent activities. The self-regulatory mechanisms of these organizations can provide valuable assistance in detecting illegal activity.

One year ago, the AMA testified on these same issues before the House Judiciary Crime and Criminal Justice Subcommittee. On that occasion, we welcomed the commendation of Assistant FBI Director Larry Potts who highlighted the Bureau's "close cooperative effort with industry groups such as the American Medical Association," in identifying criminal action.

2. AMA FRAUD AND ABUSE HOTLINE

The AMA has established a system whereby medical societies or individual physicians can report fraud through the AMA by dialing our toll-free hotline. Response to the hotline has been cyclical, increasing as stories relating to health care fraud are reported in *American Medical News*. The Association has been active in seeking out stories relating to fraud in an effort to boost reporting. In the last year and a half, there have been approximately 100 telephone reports to the hotline. The 800 number is periodically published on our electronic network to which state medical associations and national medical specialty societies subscribe. Physicians, medical societies, and other health care personnel report cases of which they are aware. The AMA then prepares a memorandum on all calls it receives. The FBI Chicago Office receives this information and assumes investigatory responsibility by sending the

information to the local agent in the area from which the complaint was reported. The FBI makes a determination as to whether an investigation will be initiated. The AMA is proud of the hotline as an excellent model of partnership between the private sector and federal law enforcement authorities on this critical issue.

3. HEALTH CARE COMMISSION ON FRAUD AND ABUSE

While more criminal investigations by the FBI, the Inspector General, and the states will succeed in eliminating some of the immediate problem, law enforcement alone will not create an environment in which fraudulent and wasteful activity will become only a marginal concern. As stated earlier, the most effective initial step will include accurate identification of the dimensions of health care fraud and abuse so that investigatory resources may then be focused in a manner that will address the causal agents and not merely the isolated criminals.

The establishment of a national commission on fraud and abuse would be beneficial, as it could explore mechanisms to facilitate fraud detection, such as allowing health benefit plans to exchange information for coordinating prosecution efforts and to ensure the availability of appropriate and effectively applied resources to law enforcement authorities to combat fraud and abuse. However, any measures taken must proceed cautiously. Even seemingly innocuous actions, such as information exchange systems and other investigatory activities, must be carefully weighed against potential sacrifices of patient confidentiality protection. Through careful consideration of such concerns, the commission could provide a valuable means to target and focus activity to address this critical issue.

4. PROFESSIONAL SELF-REGULATION

The medical community had been subjected to unreasonable constraints in recent years from efforts to discipline itself by state and federal antitrust laws that inhibited the ability of organized medicine to assume an expanded professional self-regulatory and enforcement role. Most state and county medical societies have by-laws providing for standing committees designed to mediate and resolve patient grievances and to discipline members who engage in unethical conduct. While some of these societies continued to hear patient complaints about fees notwithstanding the threat of antitrust exposure, these committees became inactive or underused in many, if not most, geographic areas.

In 1992, the AMA and the Chicago Medical Society (CMS) filed a petition with the Federal Trade Commission (FTC) requesting an advisory opinion that would permit the AMA and its constituent and component medical societies to engage in professional peer review of physician fees pursuant to procedures developed by the AMA. In order to expand the restrictive nature of the FTC guidelines in effect, the AMA proposal recommended: (1) mandatory participation in fee peer review and mediation by medical society members; (2) disciplinary action for members who engage in egregious conduct, including fee gouging; and (3) public disclosure of disciplinary actions for egregious conduct.

On February 14, 1994, the Federal Trade Commission issued its advisory opinion in response to the AMA/CMS petition on the permissibility of professional society peer review of physicians' fees under the antitrust laws. The FTC stated that the proposed program would not be violative of the law as long as the disciplinary process is limited to certain abusive practices. Mandatory physician participation in advisory fee review was determined to be "reasonably related" to making information about fees available to consumers, without infringing upon competition. Patient grievance committees acting in an advisory fashion and rendering nonbinding decisions in hearing complaints of fee gouging, would be permissible. The opinion further stated that the antitrust laws do not preclude professional groups from protecting consumers by disciplining group members who have engaged in abusive conduct such as fraud, intentional provision of unnecessary services, or exercise of undue influence over a vulnerable patient. The Commission refused, however, to permit discipline based solely on fee levels without the presence of other abusive conduct. It recommended that the AMA could require physicians to disclose relevant information to patients in advance when possible.

The FTC opinion represents an important first step in resurrecting the constructive activities of professional societies and patient grievance committees on this sensitive issue. The American Medical Association has encouraged physicians to volunteer fee information to patients and to discuss fees in advance of services where feasible.

We further believe that carefully designed legislative immunity from the federal antitrust laws for medical self-regulatory entities engaged in enforcement activities designed to promote the quality of care must be recognized. By lending statutory

reinforcement to the February 1994 advisory opinion of the FTC, progress would be advanced to an even greater degree in this area. It would also enable the medical profession to play a more active role in the elimination of health care fraud and abuse. In addition, statutory immunity should be afforded to those who provide information in good faith leading to prosecution and conviction of health care offenses.

Any proposed legislative solution should incorporate this approach, and it must be carefully crafted to clearly illuminate the parameters of a fraudulent practice. A number of major health system reform proposals, including S. 1743, the "Consumer Choice Health Security Act of 1993," and S. 1770, the "Health Equity and Access Reform Today Act of 1993," contain this type of provision. In addition, the AMA strongly supports S. 1658, the "Health Care Antitrust Improvements Act of 1993," introduced by Senator Orrin Hatch (R-UT). This measure would permit medical self-regulatory entities to engage in standard setting and enforcement activities designed to promote the quality of health care provided to patients, without the threat of antitrust sanction. We urge that any health system reform proposal that is considered by this Committee and the Senate incorporate this approach as well.

5. MEDICAL SOCIETY GRANTS

Another mechanism for health care fraud and abuse detection should include the award of grants to medical societies for the establishment of programs specifically targeted toward this issue.

Medical societies presently lack the resources to launch comprehensive initiatives to investigate and study these issues. The majority of their disciplinary activities are directed at problems relative to fee disputes impaired physicians or sexual misconduct. An award grant program would better enable medical societies to explore mechanisms to facilitate fraud detection at the local level, work with state medical disciplinary agencies to identify those who commit health care fraud, and ensure that appropriate sanctions are imposed. The AMA applauded the provisions in S. 2652, the "Health Care Fraud Prosecution Act of 1992," introduced by Chairman Biden in the 102nd Congress, that included a medical society grant award program.

6. STATE LICENSING BOARDS

The state medical and licensing boards, through their authority to license and discipline health care professionals, also have an important role to play in any organized effort to address health care fraud and abuse. The AMA urges the Committee to pursue discussions with the Federation of State Medical Boards regarding possible strategies to achieve the goal of strengthening the ability of state agencies in this regard.

7. SILENT PPOS

The AMA has uncovered information that strongly suggests that insurance companies across the nation are using misrepresentations to secure inappropriate PPO discounts from physicians and hospitals. Providers enter into PPO contracts to secure increased referrals by virtue of financial incentives for beneficiaries to use "preferred" providers. In exchange, the providers offer discounted fees to the PPO. Hospitals and physicians are susceptible to abuse of their legitimate PPO contracts when insurers use misrepresentations to claim discounts to which they are not entitled. These insurers, often using brokers, will gain access to the provider roster of legitimate PPOs and, whenever a beneficiary in an indemnity (non-discounted fee-for-service) plan visits a provider under contract to the PPO, misrepresent their indemnity beneficiaries as PPO members. Because health care claims processing is largely based on trust, physicians and hospitals may not take the steps to verify whether the beneficiary is in fact a member of the PPO. As PPO discounts can be large, often 20 to 30 percent, this scheme illegally deprives providers of huge sources of legitimate income. The AMA has reported this information to appropriate enforcement agencies.

CONCLUSION

In conclusion, the AMA underscores its commitment to eliminate health care fraud and abuse wherever it exists. We welcome the opportunity to work with Congress and others on this issue so that our health care resources may be maximized to focus on our mutual goal—the provision of quality health care to all of our citizens.

The AMA appreciates the opportunity to appear before this Committee. At this time, we will be pleased to respond to questions.

American Medical Association

Physicians dedicated to the health of America

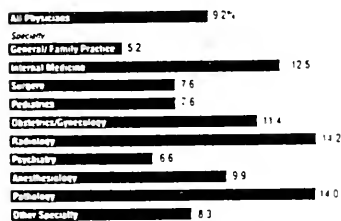


Physician Marketplace

Volume 3 Number 4, July 1992

Physician-to-Hospital Payments

Figure 1
Percentage of Physicians with Hospital Leases, by
Specialty, 1991*



* Source: AMA Socioeconomic Monitoring System 1991 core survey of
university-affiliated physicians, excluding residents.

Figure 2
Percentage of Physicians with Hospital Leases, by
Census Division, 1991



Source: AMA Socioeconomic Monitoring System 1991 core survey of
university-affiliated physicians, excluding residents.

Anecdotal evidence has suggested a rising incidence of hospitals requiring physicians to make payments for hospital services. Applying the reasoning of the Ninth Circuit Court of Appeals in *United States v. Lipkus* 770 F.2d 1447 (1985), an October 1991 report from the Office of Inspector General concluded that an *illegal kickback* occurs when a contract between a hospital and a hospital-based physician calls for the rental of space or equipment or provision of professional services on terms other than fair market value. Data from the Socioeconomic Monitoring System (SMS) 1991 core survey permit an analysis of the potential magnitude of this problem. The data have been analyzed by David W. Eminons, Ph.D., of the American Medical Association's Center for Health Policy Research, and his findings are presented in the remainder of this report.

An upper bound on the number of physicians with potentially questionable contracts is provided by the proportion of physicians with a lease arrangement, whereby they, or their practice, compensates a hospital for use of services such as space, equipment and personnel (hereafter, referred to simply as a lease). Figure 1 shows that 9.2% of all physicians have such a contract. Significant variation occurs by specialty; the proportion of physicians with a lease ranges from a low of 5.2% among general/family practitioners to a high of 14.0% and 14.2% among pathologists and radiologists, respectively.

Regional variations in lease-contracting reflect both the geographic distribution of specialties and regional differences in contracting practices. As shown in Figure 2, physicians in the East North Central states most frequently reported having a lease, 14.2%, in contrast to physicians in the Mountain states, only 5.2% of whom reported having one.

Alternative measures of the extent of the problem identified by the Inspector General are provided by responses to two additional questions on the SMS survey.

Table 1
Percentage of Physicians Asked for Payments, 1991

	Either	Patient Privileges Only	Services Only
All Physicians	6.9%	3.4%	4.6%
Specialty			
General/Family Practice	3.1	1.9	1.3
Internal Medicine	6.4	3.2	3.9
Surgery	5.9	2.9	4.4
Pediatrics	9.3	6.1	4.2
Obstetrics/Gynecology	4.1	1.5	2.7
Radiology	11.4	4.6	10.8
Psychiatry	7.0	3.6	4.1
Anesthesiology	9.8	5.1	7.7
Pathology	12.2	3.6	11.1
Other Specialty	10.7	5.1	7.3
Region			
New England	7.9	3.7	5.0
Middle Atlantic	10.6	4.8	6.5
East North Central	7.8	3.5	5.4
West North Central	3.8	0.7	3.5
South Atlantic	4.7	2.6	2.8
East South Central	3.3	1.0	2.3
West South Central	5.4	2.2	3.9
Mountain	7.9	3.8	4.6
Pacific	7.1	5.1	3.5

Source: AHA Socioeconomic Monitoring System 1991 core survey of hospitals; patient care physicians, excluding residents.

(1) Whether any hospital had ever requested the physician (or the physician's practice) to make payments to the hospital for the privilege of serving patients there

(2) Whether the physician had ever been asked to make payments to a hospital for the privilege of utilizing space, supplies, equipment, utilities, hospital employees, or billing information

Table 1 summarizes the responses to these two questions. The first column of Table 1 shows the proportion of physicians who responded in the affirmative to either of the two questions. The proportions of affirmative responses to each question individually are reported in columns 2 and 3. Overall, 6.9% of physicians had been asked by a hospital for payments. This percentage appears to be at odds with the proportion of physicians who reported they had a lease with a hospital (9.2%). Because questions 1 and 2 encompass a wide range of hospital/physician financial arrangements and merely being asked to make a payment does not mean that the physician complied, it would be expected that this proportion would be higher than the proportion of physicians indicating that they had a lease. One plausible explanation for the apparent discrepancy is that the lead-in phrase "Has any hospital ever requested..." led physicians to report only instances where a hospital had initiated such a discussion.

Table 1 also provides breakdowns by specialty and census region. The patterns largely parallel those observed on the earlier question. By specialty, pathologists and radiologists were most likely to indicate having been asked by a hospital to make payments. By region, physicians in the Middle Atlantic states were most likely to have been asked.

In order to assess the magnitude of the amounts involved, physicians who had been asked for payments were asked if they were currently making such payments and how much, per physician, those payments were. Slightly more than one-half indicated that they currently made such payments. The latter group reported average payments per physician, of \$2525.

The data reported here should be interpreted with caution. The Inspector General concluded that an illegal kickback occurs when a hospital contract calls for payments on terms other than fair market value. These data do not reflect the presence or absence of the latter property in the payments that physicians are making to hospitals. Nonetheless, the data do delineate some boundaries as to the prevalence of kickbacks being sought by hospitals.

Unlock jailed docs to provide medicine to the poor

Card Slim Robertson, once a respected doctor working in a poor Detroit health clinic, now wears federal prison blues. Instead of saving lives, she files photographs.

The 43-year-old specialist in child biology is serving 12 years on Medicaid fraud charges stemming from her work at a clinic that dispensed prescription drugs used by drug addicts.

She was fired out of medical school at the time, working only part time at the clinic. While looking down a full-time job elsewhere and caring for her newborn.

"My biggest mistake was being too overcautious," she says. "And I never did any



thing wrong. I just did my best to help the poor and elderly. Whether she's right or wrong, no purpose is served by jailing

her — or others like her — at taxpayers' expense. Instead, she could provide medical help to the underserved inner-city poor, who flood local emergency rooms because the clinic she worked in was closed.

Certainly Medicaid fraud must be investigated. But as the process works now, the poor are victims of the persecution, not beneficiaries. They are left without doctors to care for them.

The average U.S. doctor-patient ratio is 1 to 260, but for black people in the rural south and in urban ghettos it is about 1 to 400.

Yet Robertson is only one of many doctors and pharma-

cists serving harsh sentences for Medicaid fraud. Others have fought off prison investigators, but at the price of lost careers.

In Dewey Davis Jr. of Dayton, Ohio, for instance, prisoned without incident for 35 years until he was targeted by Medicaid investigators.

Even though he has never been arrested or charged, in 1980 police raided his office, seizing more than 300 of his patients' files.

Many of those patients took to the streets to protest because missing records meant lost health care and workers' compensation benefits.

One day after police raided his office, he suffered a

stroke, which he blames on government harassment. The resulting physical impairment is now the price of a move by state law. Others to revoke his license.

One less doctor to serve the poor.

Robertson, meanwhile, faces parole hearings next month. Several medical clinics have asked that she be released to perform community service work, but she says her future remains cloudy.

At a time when doctors are refusing to treat Medicaid patients, and with AIDS and TB ravaging poor communities, it is criminal that Robertson and others like her are barred from aiding the poor.

ATTACHMENT C

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Report: C

Subject: Conflicts of Interest: Physician Ownership of Medical Facilities (Resolutions 137 and 188, A-90)

Presented by: Oscar W. Clarke, MD, Chairperson

Referred to: Reference Committee on Amendments to Constitution and Bylaws, (Jerome K. Freedman, MD, Chairperson)

INTRODUCTION

At the 1990 Annual Meeting, the House of Delegates referred two resolutions to the Board of Trustees regarding physician ownership of medical facilities. Resolution 137, introduced by the American Society for Therapeutic Radiology and Oncology, called for reconsideration of the Association's guidelines on passive investments in radiation therapy facilities by physicians who refer patients to those facilities. Resolution 188 requested the Council on Ethical and Judicial Affairs to declare it unethical for physicians to refer patients to a medical facility if the physicians or their families hold a financial interest in the facility and the facility is outside of the sphere of the physicians' medical expertise.

The Council presented an Interim report in response to these resolutions at the Annual Meeting in 1991 which called for aggressive enforcement by state and county medical societies of the Council's existing guidelines on conflicts of interest. This report responds to the substantive issues raised by the resolutions. The Council is recommending a change in the Association's approach to the question of self referral.

BACKGROUND

The Council issued a major report on conflicts of interest in the practice of medicine in 1986. The Council's view then was that conflicts are inherent in the practice of medicine and that the problem of referral of patients to outside facilities in which physicians have an investment ("self referral") was not significantly different in principle from other conflicts presented by fee-for-service medicine. In a report in 1988 the Council also identified the patient conflicts presented by certain managed care arrangements, particularly HMOs which reward physicians for providing less care.

With all of these arrangements, the Council's primary guidance was to remind physicians that the profession of medicine is unique and that physicians are expected to put their patients' interests first. Thus, where a physician's financial interest may conflict with the best interests of a patient, it is assumed that the physician will not take advantage of the patient.

The Council did recognize that some arrangements may present too great a conflict to be appropriate, but with regard to self-referral the Council issued a list of safeguards to help ensure that the patient's interests would not be jeopardized. That list was most recently updated in 1988.

Since these reports and opinions were issued, several studies have been performed analyzing self-referral and drawing conclusions with regard to increased utilization and cost of the practice.

At the request of the Council, the AMA's Center for Health Policy research reviewed this evidence. The review focused on the three studies that provide original data and analyses on the effects of self-referral on utilization and costs: (1) *Financial Arrangements Between Physicians and Health Care Facilities*, a 1989 report by the Office of the Inspector General of the Department of Health and Human Services; (2) *Joint Ventures Among Health Care Providers in Florida*, a recently completed study issued by the Florida Health Care Cost Containment Board; and (3) "Frequency and Costs of Diagnostic Imaging in Office Practice—A Comparison of Self Referring an Radiologist-Referring Physicians," an article by Bruce J. Hillman and others that appeared in the *New England Journal of Medicine* (December 6, 1990).

Although the Center found that all of these studies have flaws, several important points could be made with regard to their findings:

- In the neighborhood of 10 percent of physicians nationwide have ownership interests in health care entities that have been associated with potential self-referral issues. However, not all of the physicians with such ownership interests engage in self-referral, so other motivations exist for physicians to make such

investments. Moreover, there is significant geographic variation in the extent of physician ownership of health entities that is not readily reconciled with differential opportunities to self-refer.

- For several important classes of services for which physicians make referrals, patients of physicians who self-refer have higher utilization rates than other patients. None of the studies, however, examined the appropriateness of the utilization levels of physicians who self-refer and those who refer to other sources.¹
- There is no evidence in these sources on the extent to which physicians may profit from self-referrals, so the degree of the conflict is not known, except anecdotally.

The advisory panel

The Council also appointed an expert advisory panel to assist it. The panel members consisted of Russel Patterson, MD, Chief of Neurosurgery at Cornell University, New York and a former Chairman of the Council, Newton M. Minow, senior partner in the law firm of Sidley & Austin, former FCC Chairman, Trustee Emeritus of the Mayo Clinic, Director of the Rand Corporation and Director of the Annenberg Washington Program of Northwestern University, and Robert Veatch, PhD, Director of the Kennedy Institute of Ethics. The panel studied the data and other evidence with regard to physician self-referral and reviewed the Council's prior reports and opinions.

The panel members met with the Council and provided an important perspective on the issue. The panel made no formal recommendations to the Council but assisted the Council in establishing a framework for analysis of the issue. The panel identified several considerations of particular significance:

- The medical profession's ability to preserve autonomy and the nature of the physician-patient relationship during periods of transformation have succeeded in large part due to the profession's lack of tolerance for "commercialism" in medicine.
- Government policies toward the profession have been contradictory and have contributed significantly to the rise of commercialism in medicine. The Federal Trade Commission has made unfettered competition a priority in medical practice and has seen physicians primarily as businesspeople. The Commission has acted against certain professional regulatory efforts, in particular, self-imposed restraints on advertising and fees. In contrast, Congress and the Health Care Financing Administration have established an extensive system of oversight and controls that place restrictions on physician practices which are often at odds with the Commission's free market approach. The only consistent theme of government policies is their treatment of physicians as entrepreneurs rather than professionals, with little value being given to physicians' fiduciary obligations.
- The treatment of the self-referral question has important symbolic significance for the public and policymakers with regard to which of two alternative conceptualizations of the physician's role—that of professional or that of entrepreneur—the medical profession will move toward in the era of health care reform. Although physicians will unquestionably continue to be forced into business oriented behavior, and market forces will have an important function in controlling health care costs, the Association should make clear what balance will be maintained with the profession's unique ethical traditions.

A new approach recommended by the council

The Council believes that it is necessary to strengthen its opinion on self-referral. It believes that physicians in general can be trusted to deal appropriately with the conflicts presented by self-referral. Indeed, the Council believes that physician investment and self-referral have on balance been positive for patients and the nation's health care system. But anecdotes of excessive profit and utilization have been widespread, and the formal studies which have been done strongly suggest, although they do not actually prove, inherent problems with the practice.

In addition, the Council takes notice of the change in our nation's health care priorities, and in particular, of our patients' expectations about physicians. In the 1990s and beyond, the growth in the costs of health care is likely to be the dominant

¹ The HHS study found that self-referring physicians referred patients for clinical lab testing at a 45 percent higher rate than non-investing physicians; the Florida study concluded that physicians' utilization of clinical labs, diagnostic imaging centers, and PT/Rehabilitation Centers was "significantly higher" where physicians are owners; the Hillman study concluded that physicians with a financial interest in diagnostic imaging facilities referred patients at a rate of 4-4.5 times that of non-investing physicians.

concern of our patients. The nation has today, and is likely to continue to have, unparalleled availability of health care facilities and technology of all varieties.

In this environment, the Council believes that the issue of self-referral is a part of the larger issue of physicians commitment to professionalism. As professionals, physicians are expected to devote their energy, attention and loyalty fully to the service of their patients. This does not mean they cannot have outside investments and activities or that they should not invest in health care facilities. It does mean that, to the extent possible, physicians should not be in the business of profiting purely from their ability to refer patients to outside facilities. Such a practice is fundamentally different from deriving financial reward from treating patients in their offices or in outside health care facilities they have invested in at which they care for or provide services to their patients.

At the heart of the Council's view of this issue is its conviction that, however others may see the profession, physicians are not simply businesspeople with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than even the most ethical businessperson. This is the teaching of the Hippocratic oath and of the great modern teachers of ethical behavior. There are some activities involving their patients which physicians should avoid whether there is evidence of abuse or not.

Patient need and new guidelines

The Council recognizes that there are circumstances under which patients may be deprived of the best health care if physicians cannot invest and self-refer. Physicians have often been exclusively motivated by the important needs of their patients in becoming involved in such arrangements. Blanket bans on self-referral are inappropriate. Investing and referring when it is a direct extension of a physician's commitment to serve patients' needs is both ethical and desirable. But those needs must not be marginal or rationalized needs, or secondary to a profit motive, and where non-physician or non-referring physician investment is available those sources should be explored and exhausted first.

By recognizing this patient service aspect of physician investment as a basis for ethical self-referral, the Council appreciates that the effectiveness of its general prescription against self referral for profit may be weakened. Guidelines which do not effect a change in behavior or which are unenforceable because of their vagueness or breadth of exceptions do little to enhance professionalism. Indeed, they reduce the public's confidence in the profession's ability to regulate itself.

The Council does not believe that will occur here. In addition to announcing a shift in its vie about self-referral—one that finds the practice presumptively inconsistent with the physician's fiduciary duty when adequate alternative facilities exist—the Council is also establishing new and stricter formal guidelines for those physicians who, in order to serve their patients, invest in outside facilities and refer. Only where physicians can demonstrate both the absence of adequate alternative facilities—a plain medical need—and the absence of alternative financing should self-referral take place.

Compliance with these new guidelines, as well as other Council standards, will be enhanced by an increased focus on education and enforcement by the American Medical Association and the constituent state and local societies. The commitment to greater education and enforcement is discussed in a report of the Board of Trustees at this meeting.

Recommendations

Accordingly, the Council on Ethical and Judicial Affairs recommends:

- 1) Physician investment in health care facilities can provide important benefits for patient care. However, when physicians refer patients to facilities in which they have an ownership interest, a potential conflict of interest exists. In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility.
- 2) Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available. There may be situations in which a needed facility would not be built if referring physicians were prohibited from investing in the facility. Need might exist when there is no facility of reasonable quality in the community or when use of existing facilities is onerous for patients. In such cases, the following requirements should also be met:

- a) Individuals who are not in a position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment interests are offered to physicians must not be related to the past or expected volume of a referrals or other business from the physicians.
 - b) There is no requirement that any physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor.
 - c) The entity must not market or furnish its items or services to referring physician investors differently than to other investors.
 - d) The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.
 - e) The return on the physician's investment must be tied to the physician's equity in the facility rather to the volume of referrals.
 - f) Investment contracts should not include "noncompetition clauses" that prevent physicians from investing in other facilities.
 - g) Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that they will not be treated differently by the physician if they do not choose the physician-owned facility. These disclosure requirements also apply to physician investors who directly provide care or services for their patients in facilities outside their office practice.
 - h) The physician's ownership interest should be disclosed, when requested, to third party payers.
 - i) An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.
 - j) When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.
- 3) With regard to physicians who invested in facilities under the Council's prior opinion, it is recommended that they reevaluate their activity in accordance with this report and comply with the guidelines in this report to the fullest extent possible. If compliance with the need and alternative investor criteria is not practical, it is essential that the identification of reasonably available alternative facilities be provided.
 - 4) That the remainder of this report be filed.

SELF-REFERRAL CLARIFICATIONS

Clarification of recommendation 1

Facilities in which the physician directly provides care or services. Under the guidelines, physicians may refer their patients to facilities in which they have an ownership interest if the physician directly provides care or services. The Council drew a distinction between the physician who benefits financially from services that the physician actually provides and the physician who benefits purely from the ability to refer patients for services. Thus, for example, a surgeon may operate on a patient at an ambulatory surgical facility in which the surgeon has an investment interest. [While self-referral is permissible, there is still an obligation to comply with recommendations 2.b. through 2.j.] The requirement that the physician *directly* provide the care or services should be interpreted as commonly understood. The physician needs to have personal involvement with the provision of care on-site.

Clarifications of recommendation 2

Demonstrated need. Demonstrated need might exist (a) when there is no facility of reasonable quality in the community or (b) when use of existing facilities is onerous for patients.

No facility of reasonable quality. Self-referral cannot be justified simply if the facility would offer some marginal improvement over the quality of services in the community. The potential benefits of the facility should be substantial to justify assuming the risks of self-referral. The question is whether the community has facilities that can provide medically appropriate services.

The community. The community should be defined liberally since concerns about patient convenience are included in the next criterion. Thus, the community would be the metropolitan area for a city, or the community for a rural area.

Use of existing facilities is onerous. This guideline permits newer facilities when use of existing facilities creates a hardship for patients. This might occur, for example, if existing facilities are so heavily used that patients face undue delays in receiving services. A delay would become undue if putting off the service could compromise the patient's care, i.e., it would affect the curability or reversibility of the patient's condition. There would also be a hardship if patients had long travel times that made it difficult for them to receive services. The appropriateness of the travel time would depend in part on the frequency of the service. Longer travel times would be acceptable if patients tended to use the facility rarely, while longer travel times would be unacceptable if patients tended to use the facility more regularly.

Alternative financing. The requirement that alternative financing not be available carries a burden of proof. If the facility serves a real need and is financially viable, then capital should generally be available to support it. The burden on the builder of the facility is to show that adequate capital could not be raised without turning to self-referring physicians. As to the kind of efforts that must be made to secure alternative financing, the builder would have to undertake the usual steps that entrepreneurs undertake, including efforts to secure funding from banks, other financial institutions, and venture capitalists.

Clarification of recommendation 3:

Previous investment. Physicians who invested in facilities under the Council's prior opinion and who complied with the opinion should not be damaged by retroactive application of the Council's new opinion. To the extent feasible they should, however, begin to comply with the new opinion. If the investor were able to recover his/her initial investment, plus a reasonable rate of return, there would appear to be no loss or hardship. The Council expects that physicians could achieve full compliance within three years of the issuance of the guidelines, January, 1995.

When immediate compliance with the need and alternative investor criteria is not practical and therefore full compliance is delayed, there is still an obligation to comply with recommendations 2.b. through 2.j.

The CHAIRMAN. Thank you very much.
Mr. Mattessich?

STATEMENT OF KEVIN M. MATTESSICH

Mr. MATTESSICH. Thank you, Senator. Good afternoon. My name is Kevin Mattessich and I, of course, will rely on my formal comments and would just like to highlight some of the points as sort of a guide through them.

I am also very heartened by the fact that my comments, in light of what the others have said today, have become somewhat redundant because these are issues that, as I saw them in private practice and during a recent stint as a Federal prosecutor combatting health care fraud, really stuck in my craw, so to speak, and for which they were not adequate remedies at the time. If, in fact, the earlier comments from the Justice Department and the later comments that were made as to particular amendments to the bill come true, I think that would be a very good thing.

There are two issues I want to address in the bill. I think it has a lot of meritorious provisions and there are two things that I think

could be added to it that would address issues that are critical to the containment of health care fraud.

The first is the need to extent to all payer situations the antikickback provisions that are now found in the Medicare-Medicaid regulations that prohibit kickbacks when the services are paid with those dollars. The second is the wisdom of implementing uniform forfeiture provisions in the plan.

In instances of health care fraud, parties stand accused of defrauding debilitated individuals and depriving them of care, of injuring the public fisc by defrauding Medicare and Medicaid or other Federal programs, and also defrauding private third-party payers. I would like to describe to you some of the underlying practices that lead to such accusations and, for the reason I am about to explore briefly, why I think that certain amendments to the plan can help prevent those abuses.

Now, a few years ago in private practice, I had the fortune of meeting a fellow who was quite a character, a Texan whose nickname was Available. He allegedly was the role model for the character in the Lil' Abner cartoon strip named Available, and he was allegedly the original 5-percenter. What that means is that for 5 percent he would go out and get you anything—vintage car parts, oil rig parts. You name it, he would find it and he would get it to you.

In my more recent stint as a Federal prosecutor, I had the misfortune of meeting a different breed of 5-percenter. This is somebody who would go out and get you a——

The CHAIRMAN. How did you meet him in private practice the first time around?

Mr. MATTESSICH. A different 5-percenter. In the first case, it was actually——

The CHAIRMAN. Never mind; you don't have to tell me.

Mr. MATTESSICH. I don't think he would appreciate the tie-in.

At any rate, the latter 5-percenter that I have now met is engaged in the dishonorable practice of referring patients to facilities for referral fees, or what I prefer to call kickbacks. Now, the profit motive in these schemes is clear. The 5-percenter gets his or her cut and the health care provider is fueled by the fact that they are going to have a steady stream of income-producing patients sent in the door.

Under the current state of the law, again, the antikickback provisions of title 42 apply and 5-percenters are prohibited from trading Medicare and Medicaid patients like so much merchandise. On the other hand, where the patient is not a Medicare or Medicaid patient, the services are not paid by those programs and they can be treated in that manner.

A few examples of some of the kickbacks and the forms that they come in. First of all, doctors may receive illicit benefits under the guise of serving as directors of hospitals or other institutions. Although appearing to represent reimbursement of legitimate, needed services, these fees are all too frequently a means by which the institution pays for the referral of patients to the facility.

For example, a gynecologist may agree to perform all of his or her hysterectomies at a particular hospital in exchange for being designated as a director of the maternity ward, with few or no cor-

responding duties, and then paid hundreds of thousands of dollars in director fees based upon the number of hysterectomies performed and the stream of income-producing patients that is generated.

Second, institutions may also enter referral fees with other individuals or agencies occupying positions of trust with potential patients. Fees, incredibly, may be paid to school counselors, police or court officials who are in a position to recommend, or even to order, medical or mental health care for victims of crime or others.

Think of it. A school counselor who is responsible for counseling teenagers with drug or alcohol problems is paid for the number of his or her students who enter the treatment program at the paying facility. Sometimes, these arrangements are covered up to make it look like the counselor is providing some consulting or marketing advice, but in reality the payments are based on a body count, and that is the number of adolescents that are actually referred to the facility.

A final example. Medical supply and pharmaceutical companies may make paybacks to doctors or to others who can recommend their equipment or prescribe their medicines, and often these programs operate like the frequent flyer programs. If a doctor writes enough prescriptions, he can get a trip to Hawaii.

Now, the potential for abuse in these situations, I believe, is enormous and obvious. Financial incentives skew the judgments of those relied upon by the public, and the potential for abuse is exactly what has motivated the legislature to enact antikickback statutes in other contexts.

So, as I mentioned, the antifraud provisions of title 42 apply where there are Medicare and Medicaid dollars involved, but for millions of other citizens, however, there is not prohibition and the behavior of the referring physicians and/or advisers being motivated by undisclosed profit rather than purely the health concerns of the patient are therefore unchecked. I urge the consideration of extending the law to cover those situations.

Now, briefly, as to forfeiture, the President's bill, I believe, rightfully provides for forfeiture both of properties used in the commission of a health care offense, as defined, and the proceeds of that offense. But unlike typical criminal forfeiture laws, the proposed language provides that after a guilty verdict, there should be a case-by-case judicial determination as to whether forfeiture should occur. This requirement, respectfully, is burdensome and should be stricken.

As an attorney, I favor legislation that, in fact, requires rather than bypasses judicial review, and that is not because I want to generate additional fees for attorneys, but it is out a healthy regard for the 3-tier system of checks and balances in our jurisprudence. Where judicial review may be a shield to ill-gotten gain, the latter legislation is not only appropriate, but it is compelled by the circumstances.

I believe criminal forfeiture is a strong and just prosecutorial tool because it returns exactly what the felon has taken, and while there is no doubt that an accused is entitled to a full and fair trial, the language of the bill goes much further. It requires the court, after the person is convicted of the crime, to determine whether or

not it was of a type that poses a serious threat to the health of any person or has a significant detrimental impact on the health care system.

I believe what does is sow a bountiful harvest for the litigious 5-percenter, and I believe it will be treated to the spectacle of the defendants bringing in their witnesses, et cetera, and dragging out the judicial system. For those reasons, I think that the law should be amended with respect to forfeiture.

Thank you.

[The prepared statement of Mr. Mattessich follows:]

PREPARED STATEMENT OF KEVIN M. MATTESSICH, ESQ.

Good afternoon, Senators. My name is Kevin Mattessich. The Health Security Act incorporates several important measures for combating health care fraud. Without detracting from the Act's many meritorious provisions, I wish to comment on two possible amendments addressing issues critical to the containment of health care fraud: (1) The need to extend—to all payor situations—the existing federal law prohibiting kickbacks in connection with Medicare or Medicaid services, and (2) the wisdom of implementing uniform forfeiture provisions in the President's proposed Plan.

My comments are based on experiences both as a private practitioner and as a federal prosecutor. (My remarks, of course, are my own and do not necessarily reflect the views of my former employer, the Department of Justice, or my present law firm.) My practice specialty is the investigation and litigation of commercial and white collar fraud matters. In private practice, I have directed cases on behalf of insurance carriers in the United States, Europe and Asia, involving allegations of fraud and white collar crime such as insider trading, embezzlement, loan fraud, telecommunications fraud, computer fraud and insurance fraud. More recently, as a Trial Attorney in the Fraud Section of the Department of Justice's Criminal Division, I was involved in health care investigations whose targets were individuals and multinational corporations accused of bilking federal programs and private parties out of hundreds of millions of dollars.¹

In instances of health care fraud, parties may be accused of (a) defrauding debilitated individuals and depriving them of care; (b) injuring the public fisc, by defrauding Medicare, Medicaid and military dependents' health care programs; and/or (c) defrauding private third party payors. These are serious charges affecting the health and finances of each and every American. I would like to describe to you some underlying practices that may lead to such charges. And for the reasons I am about to explore briefly, I believe that certain amendments to the proposed health care legislation can help prevent such abuses.

1. EXTENSION OF ANTI-KICKBACK LAWS

A few years ago in private practice, I had the fortune to meet a Texan whose nickname was "Available" and about whom a cartoon character in the comic strip "Lil' Abner" is said to be based. This character was a so-called "five-percenter": for five percent of the purchase price, he would find anything, for anyone, anywhere—oil rig parts, vintage car parts, routine plumbing or building supplies. His was a time honored profession; he would match a potential buyer with a potential seller and collect a 5 percent commission if a sale were consummated.

In my more recent experience as a federal prosecutor, I had the misfortune of encountering a different breed of five-percenter, characters who were engaged in the dishonorable—and all too often, marginally legal—practice of referring patients to health care providers or prescribing treatments to patients in exchange for a referral fee or other "incentive", or what in many instances more accurately should be called a kick-back. The profit motive in this general scheme is, sadly, two-fold. Not only does the five-percenter receive his or her cut, but the institution—the health care provider which pays that cut and receives a patient—is fueled by its desire to generate profit-producing patient stays or treatments, and not necessarily by the desire to serve the public's health care needs.

¹ The President's bill includes many provisions that will facilitate investigations of this nature, e.g., procedures for the sharing of grand jury information between the Civil and Criminal Divisions, and clear cut standards for excluding convicted felons from federal programs.

Under the current state of the law, these schemes are prohibited, but only if Medicaid or Medicare services are involved. The "anti-kickback provisions" of Title 42 of the United States Code prohibit "five-percenters" from treating Medicare and Medicaid patients like so many spare merchandise parts. These schemes have flourished, however, when patients' bills are paid by either the patient or a private third party payor.

Examples of kickbacks may include the following:

"Directorships": Doctors may receive illicit benefits under the guise of serving as "directors" of hospitals and other institutions. At first blush, these fees and honors appear to represent reimbursement of legitimate and needed services. In fact, these all too frequently are a means by which the institution is paying for the referral of patients to the facility. Detailed records are kept for the number of in-patient referrals by each doctor, perhaps by intricate computer tracking systems, and directorship fees are negotiated annually based on the number of patients referred. For example, a gynecologist who agrees to perform all of his or her hysterectomies at a particular hospital may be designated as a "Director" of the maternity ward, with few or no corresponding duties, then paid hundreds of thousands of dollars (based upon the number of hysterectomies performed) in addition to fees derived as a bone fide doctor. The hospital, in turn, is assured of a steady stream of income-producing patients for its operating room and beds.

Referral Contracts With Other Persons in Positions of Trust: Institutions may also enter referral agreements with individuals or agencies occupying positions of trust with potential patients. Fees, incredibly, may be paid to school counselors, police, or court officials who are in a position to recommend—or even order—the provision of medical or mental health care for victims of crime or to others who may be wards of the state. Further, union benefit administrators or therapists provided by companies may also collect such fees. Think of it: a school counselor who has responsibility for counseling teenagers with drug or alcohol problems is paid for the number of his or her students who enter the in-patient treatment program at a facility which pays for such referrals. Sometimes, these arrangements are covered up by making it appear that the counselor has been paid to perform some marketing or consulting service, but in reality the payments are based on a "body count": the number of adolescents referred to the facility.

"Frequent Prescriber Programs": Medical supply and pharmaceutical companies may make paybacks to doctors or other health care providers who recommend or prescribe their equipment or products (regardless of the actual need of the patient). Often, these programs operate like the airlines' frequent flyer programs: a doctor who writes enough prescriptions may qualify for a trip to Hawaii. Often, too, attempts are made to disguise these arrangements by requiring the doctor to submit patient profiles so it might appear that the doctor is simply being rewarded for providing marketing demographics to the company (itself a questionable practice where it is based purely on profit motive).

Relevance of Kickback Statute Rationale: The potential for abuse in these situations is obvious and enormous: *Financial incentives skew the judgments of those relied upon by the public for advice*. This potential for abuse of the discretion and otherwise humanitarian judgments of those occupying positions of trust relative to those in positions of need is exactly what has motivated the legislature to enact anti-kickback statutes in other contexts.

Of course, where Medicare/Medicaid dollars are involved, the anti-fraud provisions of Title 42 already apply. And indeed, the manner in which many health care providers evade Title 42's prohibitions is to exclude Medicare/Medicaid patients from consideration under their referral or "frequent prescriber" agreements. For millions of other citizens, however, there is no such ironic check on the behavior of their referring physicians and advisers. The egregious, recurring cases—patients following advice which is motivated by undisclosed profit rather than solely by health care concerns—are escaping prosecution.

II. THE FORFEITURE PROVISION IN THE PRESIDENT'S BILL

The President's Bill rightly provides for forfeiture both of properties used in the commission of a health care offense and of the proceeds of that offense. But unlike the typical criminal forfeiture laws, the proposed language requires that after each verdict of guilty is rendered, there be a case-by-case judicial determination as to whether forfeiture is appropriate. I believe the requirement for an additional judicial determination is unduly burdensome and should be stricken from the proposed legislation.

As an attorney, I favor legislative provisions requiring rather than bypassing judicial review—not because I wish to generate additional fees for lawyers, but out of

a healthy regard for the three-tier system of checks and balances ingrained in our jurisprudence. But, where judicial review may be used to shield ill-gotten gain, the latter legislation is not only appropriate, but compelled.

Criminal forfeiture of the proceeds of crime is a strong and just prosecutorial tool: it returns what the felon has stolen. Many on the lecture circuit now deride forfeiture; but the essence of health care fraud—the abuse of positions of trust—demonstrates its justification.

There is no doubt that one accused of such a crime is entitled to a full and fair trial to determine whether he or she, in fact, committed the crime. Yet the language of Section 4532 of the Health Security Act goes much further, providing that *after* a person is convicted of a Federal health care offense, a court may order forfeiture only if it then also determines that the offense “is of a type that poses a serious threat to the health of any person or has a significant detrimental impact on the health care system.”

This language sows a bountiful harvest for the litigious five-percenter. After being convicted of health care fraud, he or she will get a second bite at the judicial apple, by making sentencing arguments that the specific crime committed did not pose a “serious threat to the health of any person or a significant detrimental impact on the health care system.”

Respectfully, it does not take a judge to determine that implementing a kickback or other incidents of health care fraud cause harm to the system. This body can and should make that determination, sending a clear beacon of advice to the industry. The present language only gives an arguably ingenuous person, with dollars to burn, the opportunity to tax the judicial process. (Again, the accused will have their day in court; we are concerned here only with the penalties that will apply after a full and fair trial and conviction.)

Even more troubling is the prospect of a convicted doctor arguing that his or her activity did not pose “a serious threat to the health of any person”. My position, of course, is that the original fraud, by its very nature, constitutes a serious threat to the health of the defrauded person. The drafters obviously differed, but consider the burden involved in determining whether this standard is met. Defense and prosecution alike presumably would have to call expert witnesses. The expense and effort involved in such activity—at sentencing stage—would be staggering. These economics should not be visited upon the judiciary.

And most importantly: the underlying message—that conviction of the underlying offense is not sufficiently egregious to justify forfeiture of the ill-gotten gains—should not be visited upon the American public.

Thank you for providing me with the opportunity to express these views.

Respectfully submitted,

KEVIN M. MATTESSICH, ESQ.,
Morris, Mahoney & Miller.

The CHAIRMAN. Thank you very much. Before we go on, does the AMA have a position on broadening the antikickback provisions and on forfeiture expansion?

Mr. JOHNSON. Yes, we do, Senator. We just think you have to be cautious about it. We think if it is genuine fraud, we ought to get it, and you can broaden it. But some of the things are ambiguous. Some of the things are new ways of doing business, and you need to sit down, really, with the lawyers who make these arrangements on both sides and find out where the real abuse is or where you have a new way of delivering managed care or a new way of incentivizing whomever to do one thing and the other.

It is so damn complicated today that I don't even begin to try to understand all those rules. You have to have a lawyer who devotes all his time to figuring out what you can pay for, what you can be reimbursed for. Straight, dishonest kickbacks are out. If you are paid for a referral or you are paid for providing a service, that is it, that is fraud. We ought to extend that.

But if you are talking about marginal things in gray areas that you need two lawyers to tell you whether that is honest or dishonest in the eyes of the Government, that is a mistake and that is a waste of resources.

The CHAIRMAN. But that is the way it is now with regard to Federal programs, right?

Mr. JOHNSON. That is the way it is now, and if we can focus in on what the real crimes are—and you can find the lawyers who do this. The National Health Association has got a bunch of them who can sit down and separate out what is really abuse and really fraud and what are business arrangements that you really shouldn't be wasting your energy, time and effort on like it was an IRS investigation where 3 people will give you a different view. That is our only concern.

The CHAIRMAN. How about forfeiture?

Mr. JOHNSON. If it is fraud, it is fine. If it is marginal stuff or there hasn't been a clear showing that this is a bad actor, we are not in favor of that.

The CHAIRMAN. I think you are going to lose on both.

Mr. JOHNSON. Well, restitution is absolutely fine.

The CHAIRMAN. No, no, no. I am talking about the requirement that a judge sit down after the conviction, after a jury has convicted someone, and decide whether or not this is a serious offense, as opposed to whether or not, like in every other proceeding—

Mr. JOHNSON. We just waste so much time. I see it all the time in my office. We have teams of people analyze these things and the amount of time that is spent on the marginal stuff, as opposed to the really clear things, is just disproportionate today. There is enough fraud out there—God knows there is enough fraud out there that if we could focus on that and incentivize our people to go after that—

The CHAIRMAN. But what confuses me about the position on forfeiture is this is after there has been a conviction. This is after there has been a conviction and after there has been a determination that it is fraud.

Mr. JOHNSON. We have no problem with that.

The CHAIRMAN. The way the law is written now, though, after that, unlike in any other conviction where forfeiture applies, the judge then gets to sit down and say, well, you know, this is fraud, it did happen, but it is a little thing, so I am not going to make you forfeit, whereas if you do that as a businessman, the same exact thing, the judge says, hey, it is fraud, the jury said it is fraud, you have been convicted, the appeals are exhausted; it is fraud, there is a conviction, you forfeit. So you don't have objection to that, do you?

Mr. JOHNSON. No.

The CHAIRMAN. OK, all right.

Mr. Mahon?

STATEMENT OF WILLIAM J. MAHON

Mr. MAHON. Thank you, Mr. Chairman. As this is the last official word, so to speak, I will try to keep it concise and not take too long.

The CHAIRMAN. You have all waited and I am not going to curtail your time, and I am happy to sit here as long as you have something to say.

Mr. MAHON. Well, we appreciate the invitation to testify, and I must say we are well aware and very appreciative of your and your fellow committee members' longstanding concern with this problem

and we are delighted to see this committee resuming its activity in this area.

The National Health Care Anti-Fraud Association, as Mr. Mangano alluded to earlier, has, since 1985, represented a partnership of private insurer antifraud operations and the public sector law enforcement agencies who have jurisdiction to investigate and prosecute fraud against either private or public payment programs.

We are not a lobbying organization. We conduct two sets of principal activities. One is cooperative education and training, so that within our membership we cross-pollinate the best knowledge there is with respect to detecting, investigating, prosecuting—

The CHAIRMAN. Who are your members?

Mr. MAHON. On the private sector side, we have 60 commercial insurers and private payers. They are commercial carriers, Blue Cross/Blue Shield plans, one third-party administrator. On the public sector side, we work with the Department of Defense, OPM, the inspector general's office at HHS, the antifraud people at the Health Care Financing Administration, the Postal Inspection Service. We work closely with the FBI and with the U.S. attorneys' offices and some of the main Justice personnel here in Washington.

The CHAIRMAN. Thank you.

Mr. MAHON. As I mentioned, our principal activities are nuts-and-bolts education in the detection, investigation and prosecution, both civil and criminal, of health care fraud.

Second, which we have conducted since our inception, is the legally-controlled and conducted sharing of investigative information not only between insurers and law enforcement, but most importantly among insurers or private payers themselves, the point being that one payer needs a legitimate and safe legal channel through which it may learn that another payer is investigating a given provider and for what types of suspected activity.

The company cannot deny claims based on that knowledge. It can't black-list that provider, but in a practical world it can then decide whether it will investigate its dealings with that same provider to see if it finds evidence of the same suspected activity.

The CHAIRMAN. But this is suspected activity. This isn't proof of—

Mr. MAHON. That is correct, yes, and it goes to what I will describe in a moment as the basic nature of the problem.

The chart obviously tells the story of why the private sector's role in addressing health care fraud is essential, in that private dollars pay most of the Nation's health care bill. There is a lot in our prepared testimony that talks about the nature and the scope and the impact of health care fraud. Most of it echoes what most of the witnesses today have had to say on those subjects, and I would second virtually all of it, especially the idea that there is no mistaking whose money is being stolen in the end. It may be the Government's and the insurer's immediate loss, but it is all coming out of the same citizen's pocket in the end.

In deference to Mr. Johnson, I would also note by no means do we consider this to be a physician problem strictly. As has been said, wherever in the system there is an opportunity to bill a payer, there is the opportunity to commit fraud. It goes across the board and it is not limited to or unique to physicians.

Mr. Chairman, were Senator Cohen still here, I would be doing a "this is your life" type of thing to him. The best illustration and the most timely one I have seen of various facets of the problem came in today's Philadelphia Inquirer. The lead sentence of the article titled "Philadelphia Doctor Charged with Insurance Fraud" says:

When a U.S. Senate committee went looking for an expert on health insurance fraud in 1981, it called on Richard Joseph Conus. He had, after all, been convicted of cheating health care insurers in 3 States for as much as \$500,000. 'The system is extremely easy to evade,' Conus told the committee. 'The forms I sent in were absolutely outrageous.'

That 1981 statement came in testimony before the Senate Special Committee on Aging, and ironically, 13 years later, Dr. Conus still apparently could not resist. The FBI arrested him yesterday in Philadelphia and charged him again with defrauding several private insurers to the tune of hundreds of thousands of dollars. He has a total of seven arrests and five convictions in three States for defrauding Medicare and private payers since 1974.

In other aspects that have been cited today, he is said to have deposited \$2 million in foreign banks in the last several years.

The CHAIRMAN. This is a doctor?

Mr. MAHON. This is a doctor.

The CHAIRMAN. And he still has a license to practice?

Mr. MAHON. Well, he lost it and then the State of Pennsylvania reinstated the license, for reasons unbeknownst to me at the moment. But it illustrates, as I say, the very many facets—

Mr. JOHNSON. He is not an AMA member.

The CHAIRMAN. He is not?

Mr. JOHNSON. As of right now. [Laughter.]

If you lose your license ever, you don't get back in without a special proceeding at the AMA. So I am pretty confident he is not a member.

Mr. MAHON. As I say, having once testified to the Senate on how easy it was and how successful his fraudulent billing career had been, he still persisted in it over a decade later. I think it goes to what Senator Cohen asked about whether stiffer measures are needed and whether anything that is being discussed today represents overkill. I think it certainly does not.

At the other end of the spectrum, you have schemes like the rolling labs scheme in California, the perpetrators of which will be sentenced this June 27th in Los Angeles. That was a purely entrepreneurial enterprise set up to defraud the Government and private insurers that accounted for just under \$1 billion in false claims submitted during the 1980's. It resulted in the payment of tens of millions of dollars before the payers caught on to the scheme.

That, as I say, goes to the basic nature of the problem that you alluded to. The system assumes honesty on the part of the parties who are billing it. Its primary objective is to pay claims more and more rapidly than ever before, not to detect fraud, which is a necessarily secondary purpose.

Also, the typical fraud is aimed at a number of payers simultaneously. If you are going to steal \$100,000, you realize that you are smarter to take it in bites of \$10,000 from 10 payers than you are

by being greedy and being conspicuous with any one of them. Also, we almost never find anyone defrauding either the private or the public sector exclusively. It tends to victimize both quarters simultaneously, for the reason I just mentioned.

Increasingly, the schemes that we see are multi-State in nature. Some of the enterprises and some of the national companies that have been implicated or convicted in schemes in the last several years do business across State lines throughout the country.

Earlier, it was noted that the system is moving to a more managed care orientation and what that implies for the change in fraud itself and what we all have to be aware of. As was noted, today the incentive, if you are going to commit fraud, is to ostensibly perform more procedures for which you can bill, or perform unnecessary tests to generate billings.

The inverse incentive, I think, is a clear opportunity for fraud. If you are accepting an up-front payment for treating Ms. Jones for a year, it is to your advantage to see her twice rather than 20 times in exchange for that up-front payment, if that is your inclination to do less for the money.

We also see in managed care a higher incidence or a higher potential for kickbacks for referrals to specialists beyond the gatekeeper physician in a typical managed care plan either to specialists outside the network or within the network. We see, too, a higher potential for schemes involving the establishment of phony managed care companies themselves whose objective will be to rake in the up-front capitated payments and then disappear from sight with the money.

There are some advantages, theoretically, to managed care. Insurers, by virtue of selecting certain providers to comprise their networks, should be able to apply clean-record type criteria when it comes to fraud. It remains to be seen whether they will be able to exercise the kind of leeway they would like to see there to select up front or to inject from their networks providers whom they find are engaged in fraud.

There are, Mr. Chairman, a number of obstacles that the private sector has historically faced in addressing this problem, and we are delighted to see that the Clinton bill and some of the other approaches that have been proposed tend to address most of these concerns.

One is the fact that the private sector cannot sanction providers from doing business with private payers. They have to live with anything that they have not proven is fraud. Second, as you noted, it is not illegal to pay kickbacks for referrals for private sector business unless State law somehow outlaws it. It is not illegal to waive a patient's copayment or deductible payment when used as a marketing device. What we see is the waiver of copayment used as a hook to lure patients into what turn out to be free physical exam schemes or other fraudulent billing schemes.

The private payers in investigating fraud run the risk of civil liability to the people whom they are investigating. It is not uncommon to find, upon an insurer investigating a provider or referring a case for prosecution, for that provider to at least threaten, if not actually file, a civil tort suit for defamation, malicious prosecution, invasion of privacy, and so forth.

Some State laws give private payers a reasonable degree of immunity from that civil liability so long as they are acting in good faith in investigating and reporting suspected frauds. In other States, there is no immunity protection and, as I mentioned, many of the investigations cross State lines, which tends to render the immunity laws somewhat impractical.

Finally, the Federal Government enjoys the power of the False Claims Act, for which the private sector has no analogous legal tool. We have suggested, and we still suggest, that either in place of or in addition to the type of False Claims expansion and *qui tam* provisions that are in the administration's bill, the private sector could very well use a carefully tailored civil cause of action at the Federal level.

Right now, I am aware of private payers who are suing provider companies in a number of States simultaneously for fraudulent activity. Unless one files a racketeering suit against a multi-State scheme, one must go State by State with civil actions in order to pursue civil recoveries. We think it would be much more effective and cost-efficient for all concerned, and would have some deterrent value, to give private payers the right to sue civilly in Federal court.

Mr. Chairman, I have attached to our testimony an assessment by our general counsel that represents his personal point of view of the antifraud implications of the Health Security Act's fraud and abuse title. I would note the biggest question surrounding how we approach fraud and abuse is whether it will be done as part of reform or by virtue of putting health care fraud on a faster legislative track. In either case, I think it is evident, and we certainly believe that we need more effective measures. We need comprehensive measures, and we could all use them sooner rather than later, *vis-a-vis* health care reform.

I would also note that 20 States last year enacted new laws pertaining specifically either to health insurance or workers compensation insurance fraud. They range in scope from creating defined penalties to establishing State insurance fraud bureaus with varying degrees of investigative and prosecuting responsibility, but the States are acting quickly. Those measures are all to the good, but again I think the argument must be made that it is increasingly a Federal crime in nature and that to effectively deter it nationwide we need the Federal focus on it.

One final point, if I may, Mr. Chairman. When we look at health care reform itself, we all must keep our eyes open, I think, about what happens historically when we establish new health care benefits or broaden existing benefits. We have seen it in home infusion, in mental health in the last decade, and in other areas.

When benefits are created or expanded, for a time they tend to generate money, which in turn attracts fraud schemes. We often create cottage industries in fraud for a time until the private and public payers catch up to the fact that people are abusing these new benefits.

If we look at the areas where expansion is planned under health care reform—mental health, prescription drugs for Medicare, and home care—those three areas all have relatively high-profile fraud problems at present. No one is saying don't expand the benefits,

but as a general rule we need to keep our eyes open to the potential for increased fraud when we provide new benefits.

Mr. Chairman, thank you for your indulgence and your time. I will conclude and be happy to answer any questions.

[Mr. Mahon submitted the following materials:]

PREPARED STATEMENT OF WILLIAM J. MAHON

Mr. Chairman, Members of the Committee. The National Health Care Anti-Fraud Association appreciates your invitation to testify today, and we commend your continuing attention to a critical problem with which members of this Committee have been concerned for some time—and one on which virtually all interested parties agree that strong action is needed.

Established in 1985, NHCAA is a unique membership organization that combines the anti-fraud efforts of private-sector health care payers with those of the public-sector agencies responsible for investigating and prosecuting health care fraud. NHCAA is not a trade association, nor is it a lobbying organization. Rather, it is an issue-based Cooperative association whose member organizations account for most of the private and public health insurance benefits paid in the US, and whose objective is to improve the private and public sectors' ability to detect, investigate, prosecute (both civilly and criminally) and, ultimately, prevent health care fraud.

From the private sector, NHCAA numbers 59 commercial and not-for-profit insurers. The public-sector members of the Association's governing board are:

- The Deputy Inspector General for Investigations and the Assistant Inspector General for Civil Monetary Penalties of the Office of Inspector General of the Department of Health and Human Services;
- The Assistant Inspector General for Investigations of the Department of Defense;
- The Deputy Chief Inspector for Criminal Investigations of the US Postal Inspection Service;
- The Senior Auditor in Charge of the US Office of Personnel Management;
- The Deputy Director of the Office of Medicare Benefits Administration in the Bureau of Program Operations of the Health Care Financing Administration;
- The Director of the Florida Medicaid Fraud Control Unit; and
- The Medicaid Fraud Counsel of the National Association of Medicaid Fraud Control Units.

In addition to those officials and agencies, NHCAA works closely with the Headquarters and Field health care fraud units of the Federal Bureau of Investigation and with various United States Attorneys' offices and Department of Justice Headquarters personnel.

We also number nearly 700 individual members, from the ranks of health care insurers, third-party administrators, self-insured corporations and from a wide variety of other state and federal law enforcement organizations. [See Appendix I, *NHCAA Fact Sheet*.]

NHCAA's principal activities comprise: (1) cooperative education and training in the specifics of health care fraud detection, investigation, prevention and prosecution; (2) the sharing of investigative information among insurers and also between insurers and law enforcement agencies; and (3) communication with a wide variety of interested parties with regard to the nature, scope and impact of health care fraud and the development of more effective measures to combat the problem.

Although individual patients can, and do, commit health care fraud, our principal focus as an organization is on claims fraud committed by health care providers, simply because it is they who, if they are inclined to defraud third-party payers, are best equipped to do so on a broad scale and on an ongoing basis.

We have been asked today to offer the private sector's perspective on health care fraud and on proposed legislative approaches to the problem. The private payers perspective is essential to the discussion for three reasons:

First, according to 1992 figures from the Health Care Financing Administration, most of the nation's total health care bill—56 percent—is paid with private-sector dollars (37 percent by insurers and 19 percent by consumer out-of-pocket payments).

Second, experience clearly shows us that the health care provider who is defrauding Medicare, Medicaid, CHAMPUS or other government programs in all likelihood is also defrauding private payers—and vice versa.

Third, although insurers and the government may be the immediate targets of health care fraud, we and all our fellow citizens are its ultimate victims—as consumers and patients who pay health insurance premiums, co-payments and

deductibles; as employers who purchase health coverage for their employees; and as taxpayers, where we are doubly victimized when public payment programs are defrauded.

Health care frauds run the gamut—from individual providers who routinely fabricate or very consciously misrepresent claim information in order to receive third-party payments (or greater payments) to which they are not entitled; to medical equipment and home health businesses that prey on the Medicare program and private payers; to entities such as “rolling lab” schemes established solely as vehicles for committing fraud within the health care arena; to institutional frauds by hospitals, laboratories and clinics, all or part of whose basic business operation revolves around the systematic commission of fraud.

What these various schemes have in common is the criminal and quite deliberate intention to defraud (See Appendix II, *NHCAA Guidelines to Health Care Fraud*). As such, we must emphasize our belief that they represent the actions of a small proportion of health care providers and others in the field. Unfortunately, though, given the enormous amount of money at play in our health care system, the actions of even a tiny dishonest minority can inflict massive financial damage on both private and public payers.

One Florida physician and his spouse, for example, were sentenced to prison after pleading guilty to having filed more than \$800,000 in false claims with private payers and Medicare. In a widely reported 1992 case, a clinical laboratory firm pled guilty to filing fraudulent claims and is paying the federal government and several state Medicaid programs a total of more than \$110 million. Meanwhile, the largest ongoing scheme identified to date—the so-called California rolling lab case, to which the perpetrators pled guilty and will be sentenced this June 27—accounted for nearly \$1 billion in false claims against private and public programs during the 1980s.

How much do we lose in all?

By its nature, the amount lost to any ongoing fraud can never be quantified to the exact dollar and thus must be estimated in an educated context. In that context, NHCAA estimates the loss to outright fraud at between 3 percent and perhaps as much as 10 percent of what we spend as a nation on health care each year.

In 1994, then, when the Department of Commerce estimates that our health care expenditure will total \$1.006 trillion, that translates to a minimum loss to outright fraud of at least \$30 billion—and in all likelihood substantially more, perhaps as much as \$100 billion.

The bottom line: Even by conservative estimates, health care fraud is costing us tens of billions of dollars at a time when Congress, the Administration, the states and the public are struggling with the complex questions of funding various health care reform proposals.

How are such losses possible?

First, and as a general observation, they stem from the efforts of a small proportion of providers to defraud a system that rests on an assumption of honesty and thus is designed to pay health care claims efficiently and—often by statute—more rapidly than ever before. In that context, claims payers are being called on both to pay claims faster and faster, AND to put a stop to fraud in the system—two demands that are not easily reconciled.

Putting a stop to a given fraud means first detecting it through one or more of the various means employed for that purpose; investigating it with regard for due process; in the private sector, involving law enforcement and prosecutorial authorities at the appropriate stage; and in the case of prosecutions, proving the case.

Detecting most fraud is itself no easy matter, in that on face value, any one fraudulent claim may appear perfectly legitimate. Generally, it is only when fraudulent claims surface as part of a given pattern, or when the payer's attention is otherwise called to them, that they become suspect.

In addition, rarely do fraudulent providers victimize only one payer at a time. On the contrary, they generally—and quite deliberately—spread their activity among any number of payers simultaneously, the better to remain inconspicuous and thus prolong the detection process with each one while reaping the proceeds.

The investigation and prosecution processes also present the private-sector with a number of obstacles, both real and perceived.

First, actions that are illegal under a federal program are not always illegal when private payers are the target: for example, the payment of “kickbacks” for referral business which has a snowball effect on the volume of claims; or the waiver of the patient's insurance co-payment when used systematically as a “free-service” marketing hook with which to lure patients into fraudulent-billing schemes.

Second, the government enjoys two very effective enforcement tools for which the private sector has no legal counterparts: the ability to sanction fraudulent providers from participation in a given health plan, and the legal weight of the federal civil

False Claims Act, which imposes heavy civil penalties on any individual or entity filing a false claim against a government payment program.

Third, insurers referring cases for criminal investigation and prosecution often confront the very real hierarchy of law enforcement resources and priorities, where health care fraud cases must be weighed according to their nature and financial dimensions.

Fourth—although the sharing of case information and aggressive investigation are essential to the early detection and effective prosecution of health care fraud—insurers conducting investigations, exchanging case information and prosecuting cases in good faith, expose themselves to widely varying degrees of potential civil tort liability to the subjects of those investigations or prosecutions (e.g., for defamation, invasion of privacy, malicious prosecution).

Some state laws grant insurers relatively strong immunity from such civil liability in that good-faith investigative information-sharing and reporting activity; in other states, however, they receive no such protection at all. Similarly, the value of state immunity laws is at best limited with respect to the increasingly common circumstance of multi-state or nationwide fraud investigations. In that context, they must continually consider the risk of significant lawsuits—at best costly, even if without merit—in their aggressive pursuit of fraud cases.

Finally, private payers also face the uncertainty that a successful prosecution will result in a recovery or restitution of funds lost to the fraud. The absence of such reasonable assurance represents yet another factor that insurers must weigh in pursuing a given case.

In the last two years, several members of Congress—including the Chairman and two other members of this Committee—have introduced health care fraud bills representing a variety of philosophic and practical approaches to the problem. Today several of the health care reform plans before Congress incorporate similarly varied anti-fraud proposals. (In 1993, meanwhile, 20 states enacted new laws pertaining specifically to health insurance fraud, and more are doing so this year.)

Obviously, the adoption of a given health care reform plan will hinge on many issues far beyond its particular anti-fraud measures, and it is not NHCAA's role to comment on those overall reform issues. From our anti-fraud perspective, however, we offer the following observations:

First, we must adopt more effective measures against health care fraud—whether as part of any health care reform plan or via independent legislation.

Here we must consider the tradeoff involved in tying new health care fraud measures to the health care reform effort—a step that would delay their effectiveness pending agreement on, then enactment and implementation of any reform plan—versus the merits of addressing fraud sooner through independent legislation written so as to accommodate reform-related structural changes in the health care system.

Second, we must acknowledge that while the nature of health care fraud will certainly evolve as does the health care system itself, fraud will not be restructured or reformed out of existence. At first glance, for example, “managed-care” models of health care delivery and payment pose a variety of new challenges from an anti-fraud standpoint:

- An inverse incentive, under capitated payment plans, to *underserve* patients' medical needs: i.e., to provide less treatment than the patient requires in exchange for the fixed payment;
- A potentially higher incidence of kickbacks for referrals from “gatekeeper” physicians to specialists either inside or outside a given network of providers; and
- A higher potential for schemes involving the creation of phony managed-care entities for the purpose of stealing up-front treatment fees.

Of course, the managed-care environment also features certain theoretical advantages when it comes to fighting fraud—for example, the contractual ability to select “better” providers at the outset and to eject from one's network any found to be engaged in fraud.

We can be sure, however, that wherever more than \$1 trillion changes hands annually, some will always try to steal from the system. Our responsibility is to understand how fraud itself will continue to evolve and to better protect the system accordingly.

Finally, any truly effective new steps against fraud not only will recognize its impact on private payers, but will also take advantage of the private sector's experience and resources as a partner in fighting the problem.

Thus NHCAA suggests that any effort to maximize the private sector's effectiveness in fighting health care fraud encompass the following points:

- The creation of the specific federal crime of health care fraud and related penalties;
- The acknowledgment of the need to assemble and share information, not only on "adverse final actions" against fraudulent health care providers, but also on active fraud schemes that are under investigation; and consequently
- The standardization at the federal level of immunity from civil liability for private payers' good-faith sharing of investigative information and reporting to law enforcement on suspected frauds, based on the knowledge that such activity is essential to the early detection, effective investigation and successful prosecution of typical fraud schemes;
- The provision of a federal civil cause of action, analogous to the government's civil False Claims Act, for private-sector victims of health care fraud, to enable private payers to pursue recoveries more effectively through civil suits at the federal level;
- The preservation (if not the enhancement) of private payers' standing with respect to court-ordered restitution of fraud proceeds in criminal convictions or to the government's distribution of assets seized in health care fraud cases;
- The extension to private-sector health care dealings of the illegality of kickbacks for referrals or arrangements for the provision of health care services (with appropriate exception of any financial incentives seen as legitimately furthering the public-good purpose of managed-care health care delivery arrangements); and
- Provisions for the incorporation in electronic-claims dealings of appropriate technical safeguards against fraud—an area that, like managed care, represents both significant new problems and potentially improved opportunities with respect to the detection of fraud.

As outlined in the accompanying memorandum by NHCAA's General Counsel, the Fraud and Abuse title of the Clinton Administration's Health Security Act represents a comprehensive approach to fraud that, commendably, addresses many of the aforementioned points. [See Appendix III, *The Anti-Fraud Implications of the Clinton Health Care Proposal*.]

It does not, however, provide a federal civil cause of action for private payers; nor does it explicitly address the need to encourage private payers to share investigative information on active frauds by providing a reasonable degree of immunity from civil liability for the good-faith exchange of such information.

By its nature, the Health Security Act's Fraud and Abuse title also reflects the content and is tied to the legislative fortunes and timetable of the overall reform Act (calling, for example, for the Attorney General and Secretary of Health and Human Services to act "not later than January 1, 1996.") In that context—and given the magnitude of our estimated annual loss—one must at least examine the option of placing improved anti-fraud measures on a faster legislative track.

Alternatively, should the final product of Congressional debate on health care reform differ fundamentally from the Administration's overall plan, we must ensure that any integral approach to fraud is tailored appropriately.

Again, we commend the Committee for its thorough examination of this problem and the realization that its solution not only must involve the private sector, but must build on private payers' experience and their direct interest in fighting health care fraud more effectively.

Thank you very much for this opportunity to comment. NHCAA will be pleased to assist the Committee further in any way it deems helpful.

NHCAA

NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

FACT SHEET

Founded in 1985 by several private health insurers and federal/state law enforcement officials, the **National Health Care Anti-Fraud Association (NHCAA)** is a unique, issue-based organization comprising private- and public-sector individuals and organizations responsible for the detection, investigation, and prosecution of health care fraud.

MISSION STATEMENT

Purpose: To improve the detection, investigation, civil and criminal prosecution, and prevention of health care fraud.

- Goals:**
- Establish and maintain a pro-active stance in the fight against health care fraud
 - Conduct national seminars to educate the public and private sectors in effective methods of combatting health care fraud.
 - Expand the investigative capabilities of health care reimbursement organizations through education in the detection, investigation, prosecution, and prevention of health care fraud.
 - Provide an information-sharing network, with appropriate safeguards, to aid in the investigation of health care fraud.
 - Assist law enforcement agencies in their investigation and prosecution of health care fraud

ANNUAL TRAINING CONFERENCE

Each year, NHCAA conducts a 3-day educational conference featuring training workshops on a wide variety of anti-fraud topics and addresses by prominent leaders in the field. Future Annual Conferences are scheduled as follows:

- | | |
|-------------------------------|--|
| 1994: November 13 - 16 | Hyatt Regency Hotel - New Orleans, Louisiana |
| 1995: November 12 - 15 | Marriott Hotel - Marco Island, Florida |

MEMBERSHIP

Corporate Membership is open to private for-profit or not-for-profit health care reimbursement organizations approved for membership by the NHCAA Board of Governors. **Individual Membership** is open to persons occupying managerial, supervisory or professional positions in such reimbursement organizations; in local, state or federal law enforcement, prosecutorial or regulatory agencies; in professional associations or professional disciplinary organizations approved for membership by the Board of Governors or by the NHCAA Membership Committee.

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Blue Cross of Western Pennsylvania
 Blue Shield of California
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 Trustmark Insurance Co.
 The United States Life Insurance Co.
 United Teacher Associates Insurance Co.
 Washington National Insurance Co.
 WEA Insurance Corp.
 WellPoint Health Networks Inc.
 Wisconsin Physicians Service

PUBLIC SECTOR**Agencies represented on NHCAA Board of Governors**

Florida Medicaid Fraud Control Unit
 National Assn. of Medicaid Fraud Control Units
 US Department of Defense,
 Office of Inspector General

US Dept. of Health & Human Services
 • Health Care Financing Administration
 • Office of Inspector General

US Office of Personnel Management,
 Office of Inspector General
 US Postal Inspection Service

INDIVIDUAL MEMBERS

NHCAA has over 650 individual members from private insurance carriers, not-for-profit health insurance plans, health care reimbursement organizations, and state and federal law enforcement and regulatory agencies.

HEALTH BENEFITS PAID

In 1993 NHCAA Corporate Members accounted for an estimated **\$110 BILLION** in private-sector group and individual health benefits paid, not including benefits paid on behalf of self-insured or government programs.

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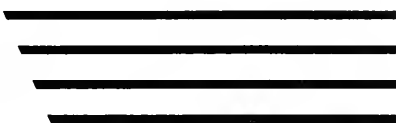
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NHCAA



NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

GUIDELINES TO HEALTH CARE FRAUD

ADOPTED BY THE
NHCAA BOARD OF GOVERNORS

NOVEMBER 19, 1991

Health care fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although the specific nature or degree of the criminal acts may vary from state to state.

The variety of fraudulent reimbursement and billing practices in the health care area is potentially infinite. The most common fraudulent acts include, but are not limited to:

1. Billing for services, procedures and/or supplies that were not provided.
2. The intentional misrepresentation of any of the following for purposes of manipulating the benefits payable:
 - a. The nature of services, procedures and/or supplies provided;
 - b. The dates on which the services and/or treatments were rendered;
 - c. The medical record of service and/or treatment provided;
 - d. The condition treated or diagnosis made;
 - e. The charges or reimbursement for services, procedures, and/or supplies provided;
 - f. The identity of the provider or the recipient of services, procedures and/or supplies.
3. The deliberate performance of unwarranted/non-medically necessary services for the purpose of financial gain.

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THE ANTI-FRAUD IMPLICATIONS OF THE CLINTON HEALTH CARE PROPOSAL,¹
 SUBMITTED BY THOMAS W. BRUNNER AND KIRK J. NAHRA²

The Clinton Administration health care reform proposal contains an elaborate section entitled "Fraud and Abuse." While the fraud and abuse provisions have not been a focal point of debate within the Clinton Administration, the plan includes a number of creative and aggressive proposals to fight fraud. With some attention by knowledgeable parties, this legislation can represent a significant opportunity to improve the investigation, detection and prosecution of health care fraud.

The Clinton anti-fraud program has three primary goals: (1) to provide a more coherent framework for civil and criminal investigative and enforcement efforts in the health care fraud area; (2) to integrate "private" third-party payers into the federal civil and criminal enforcement scheme; and (3) to broaden the civil and criminal sanctions available to fight health care fraud. Obviously, the operation and effectiveness of these proposals will depend in large part on the fate of the overall health care reform package; while the proposals typically make sense if the overall Clinton plan is adopted, some of the provisions would be substantially less applicable under other reform proposals. Because it is likely that the Clinton plan will undergo substantial legislative revision, the logic of these proposals will need to be reexamined as the legislation evolves. Moreover, to date, it is clear that the anti-fraud proposals have been almost an afterthought in the overall debate. This is likely to continue. It will be important to monitor these provisions carefully as they evolve, to ensure that the overall anti-fraud program that eventually emerges fulfills the promise of the current Clinton anti-fraud proposals.

A. ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

The centerpiece of the Clinton anti-fraud plan is the creation of an "all-payer" health care fraud and abuse control program (Part 1, Sec. 5401),³ to be established jointly by the Department of Health and Human Services (acting through the Inspector General's Office) and the Department of Justice. This program is intended to be an organized, coordinated law enforcement effort to fight health care fraud.⁴

A significant problem with this anti-fraud program arises immediately. The HHS Secretary and the Attorney General (the program directors) are to establish this program "[n]ot later than January 1, 1996," Sec. 5401(a). Accordingly, the plan will have no significant effect on ongoing anti-fraud efforts until that time.⁵ Given substantial losses to fraud each year, this delay is not acceptable to those interested in fighting fraud. Moreover, because there is more nearly a consensus as to the need for changes in the anti-fraud enforcement program than in the specific parameters of the overall health care reform plan, independent anti-fraud legislation may move more quickly than the rest of the health care reform package.

The goal of the all-payer program is threefold:

- To coordinate law enforcement functions with respect to the prevention, detection and control of health care fraud and abuse;
- To conduct audits and investigations in relation to the delivery of and payment for health care services; and
- To facilitate the enforcement of various statutes applicable to health care fraud and abuse.

In creating this program, the HHS Secretary and the Attorney General are instructed to consult with and share data and resources with federal, state and local law enforcement agencies, state Medicaid fraud control units and the state agencies responsible for licensing of health care providers. Sec. 5401(b). The officials also are

¹This memorandum has been prepared by the authors at the request of the National Health Care Anti-Fraud Association. All opinions expressed herein represent the view of Wiley, Rein & Fielding and do not necessarily reflect the view of NHCAA or any of its member individuals or organizations.

²The authors are attorneys with the law firm of Wiley, Rein & Fielding in Washington, D.C. They represent the National Health Care Anti-Fraud Association, the National Insurance Crime Bureau and various insurers and other third-party payers in a wide range of matters related to insurance fraud.

³All references to the Clinton plan are to sections of the legislation as introduced. Other references in this Memorandum are to H.R. 3080, introduced by Congressman Michel (R-Ill.), S. 491, introduced by Senator Wellstone (D-Minn.), the Cohen Amendment, introduced by Senator Cohen (R-Me.), H.R. 3222, introduced by Congressman Cooper (D-Tenn.) and S. 1770, introduced by Senator Chafee (R-RI). The Cooper bill does not contain a fraud and abuse section.

⁴The Michel proposal creates a similar coordinated program.

⁵The Chafee plan establishes a similar program no later than January 1, 1995.

instructed to consult with and share data with "representatives of health alliances and health plans." Sec. 5401(c). This provision reflects an understanding of the diversity of victims and investigators of health care fraud, as well as a recognition of the private payer expertise in this area.

In structuring and implementing this program, the HHS Inspector General and the Attorney General are authorized to carry out a number of functions. In particular, they are authorized to conduct, supervise and coordinate audits, civil and criminal investigations and other reviews of the overall anti-fraud program. Sec. 5401(d)(1). They also are authorized to obtain access to all records of health alliances and health plans relating to ongoing investigations or the imposition of sanctions involving health care services. Sec. 5401(d)(2).

This first function is simply a reiteration of the role of the directors in this scheme. The second is a substantial change, implicating a number of private sector concerns. By statute, the government would be allowed to have access to all investigative records and sanction information from all payers, public and private alike. This would substantially increase the flow of investigative information to the government. The goal of this provision is to allow government law enforcement officials to have direct access to private sector investigative information. Again, the provision demonstrates the benefits that law enforcement receives from private sector information. Because of the lack of reciprocity, either required or discretionary, however, this information exchange is likely to continue as a one-way street, with little information flowing to private sector investigators.

To facilitate insurers' provision of this information to the government, the plan also provides a qualified immunity for certain information disclosures. Sec. 5401(e). Incorporating the immunity provisions of the Social Security Act, persons providing information to the program directors "in conjunction with their performance of duties" under the program will receive this qualified immunity. Sec. 5401(e); see also 42 U.S.C. 1320c-6(a).⁶

This federal-level immunity is an important step forward. Under the Social Security Act, no persons providing information shall be held "to have violated any criminal law, or to be civilly liable under any law" unless they have provided information unrelated to their performance of duties or unless the information was false and the person providing information "knew, or had reason to believe, that such information was false." 42 U.S.C. § 1320C-6.

By incorporating the Social Security Act provision, this immunity statute fills some of the vacuum left by the patchwork quilt of current state immunity statutes. These state statutes provide varying levels of protection in certain states and may provide no significant protection in multi-state investigations. The recognition of the need for uniform federal protection is important, and may create the opportunity for broadening the available protection once this Federal line is crossed.⁷

Nonetheless, there are a few important issues to resolve. First, it will be useful to clarify the meaning of the phrase "performance of duties." Because the Clinton plan contemplates a blending of the public and private payer systems, this phrase should be interpreted broadly so that all activities involved in both anti-fraud and ongoing participation in the health care payment system will be covered. It will be important to ensure that *all* anti-fraud activity falls within the immunity.

Second, the immunity also should extend to provision of information to all law enforcement officers, not just those connected to the administration of the health care system, to encourage cooperation with these law enforcement officials. In addition, it would be useful for this immunity to apply to exchanges of information between private sector fraud investigators, as the private sector investigators often are the first wave of defense against fraud. The statute needs to apply not only to potential violations of federal and state statutes, but also to state common law claims (e.g., defamation, malicious prosecution, invasion of privacy).⁸

Next, the threshold level for providing information needs to be clarified. Because of potential liability concerns, private sector entities need to understand exactly when in an investigation this information must be provided; the earlier in the process, the less likely the information is to be complete or reliable (and the greater the burden on those who must provide information).

⁶ The Chafee bill provides similar immunity protection.

⁷ The Chafee proposal creates a national database for health care fraud information. It provides immunity as to all submissions made to this database.

⁸ The proposal as it now stands provides immunity from federal statutory claims, such as § 1983 claims, that could be made based on cooperation by insurers with the government or other activities as a potential "state actor." Given the increased public/private cooperation envisioned by the overall health care reform plan, the likelihood of this type of suit otherwise would increase.

Last, the exception for provision of false information must not prove to be a significant loophole. Many of the current state immunity statutes revoke immunity protection where a person acts with malice or bad faith. In these instances, the mere allegation in a complaint of these motives may be sufficient to remove the immunity. This immunity standard should be strengthened, by requiring that any allegation of knowledge of false information be required to be pled "with particularity," a term of art under the Federal Rules of Civil Procedure, Rule 9(b), so that there must be allegations of specific behavior beyond that normally required in a complaint. This immunity protection needs to extend not only to claims by providers that are the targets of investigations but to claims by patients whose confidential information might be released.⁹ Because the statute requires provision of this information, private sector entities should be protected from all liability for claims arising from this statutory mandate.

The Clinton plan also addresses how the new program will be paid for, albeit in vague terms. The proposal states that "in addition to" other amounts appropriated for health care anti-fraud and abuse activities, the program is entitled to additional amounts that will be necessary to enable the program directors "to conduct investigations, audits, evaluations, and inspections of allegations of health care fraud and abuse," and otherwise carry out this program. Sec. 5401(f).

The plan is not clear concerning what these additional appropriations would cover or where they would come from; nor are the "additional amounts" necessary to conduct the activities of this program specified. This provision apparently aims to provide legislative authority for additional investigative personnel, without being too specific.¹⁰

Section 5402 of the plan creates an additional funding mechanism, the "All-Payer Health Care Fraud and Abuse Control Account." This account is basically a trust fund that will provide resources for the fight against health care fraud and abuse. The account will be made up of (1) all criminal fines in cases involving federal health care offenses (defined below); (2) penalties and damages imposed under the Federal False Claims Act relating to the provision of health care items and services;¹¹ (3) administrative penalties and assessments under the civil monetary penalties provisions; (4) amounts obtained through the forfeiture of property by reason of a federal health care offense; and (5) any money gifts or bequests made to the account Sec. 5402(a).¹²

These funds may be used by the directors (without involvement of the appropriations process) to carry out the anti-fraud program, including the costs of prosecuting health care fraud matters, the costs of investigations and the costs of other audits or inspections. Sec. 5402(b). This account is supposed to supplement the agencies' anti-fraud operating budget, not supplant it. It represents an effort by the government to make health care fraud investigations a somewhat self-supporting mechanism.

This section contains the first explanation of what constitutes a "federal health care offense" under the Clinton plan. Sec. 5402(d). While not a separate crime itself, a "health care offense" is the catchword for a number of broad references under the Clinton plan. This offense includes (1) a series of new health care-specific criminal acts defined by the plan itself (discussed below); (2) any violation of § 1128B of the Social Security Act, which includes illegal remunerations, certain false statements concerning health care institutions and illegal patient admittance and retention practices; (3) violations of a variety of existing criminal provisions, if these violations relate to health care fraud;¹³ (4) violations of criminal provisions of ERISA (including coercive interference with ERISA rights, 28 U.S.C. § 1141, and general criminal ERISA violations, 29 U.S.C. § 1131), if the violation relates to health care fraud; and

⁹ Some patient-specific information is excluded from disclosure by a separate privacy proposal. See Sec. 5401(d)(2). The balance between this disclosure requirement and the patient privacy restrictions is uneasy. As it now stands, insurers are likely to continue to receive requests for patient records or other patient-specific information for which disclosure may create insurer liability. In fact, the privacy proposals expand the range of patient-specific information that is given federal protection. There is no discussion of how current regulatory requirements in the substance abuse area will be integrated into this system.

¹⁰ Some of the other proposals contain specific levels of finding for additional investigators and/or prosecutors.

¹¹ This excludes funds awarded to a *qui tam* relator or to a victim for restitution.

¹² The Chafee plan creates a similar fund, and provides an extensive discussion of the investment guidelines for this fund.

¹³ These include mail fraud (18 U.S.C. § 1341), wire fraud (18 U.S.C. § 1343), false statements in relation to ERISA (18 U.S.C. § 1027), false statements to the government (18 U.S.C. § 1001), theft or embezzlement from an employee benefit plan (18 U.S.C. § 664), conspiracy to defraud the United States (18 U.S.C. § 371), and false claims to the government (18 U.S.C. § 287).

(5) various violations of the Federal Food Drug and Cosmetic Act, if the violation relates to health care fraud. *Id.*

The proposal also discusses other types of funds that various health care investigative offices may receive. The HHS Inspector General's office may receive and use reimbursement for the costs of its investigations, if ordered by a court as part of restitution or where voluntarily agreed to by a provider. Sec. 5403(a). A separate fund is established for all money that has been transferred to the Inspector General's Office from the Department of Justice Asset Forfeiture Fund. Sec. 5403(b). Given the extensive losses due to fraud and the perhaps heightened competition between the various government entities and other victims for limited funds recoverable from health care fraud defendants, it is important to ensure that victims' rights, including those of health insurers and other third-party payers, are given an important priority in the distribution of money obtained from convicted providers.¹⁴

B. APPLICATION OF FRAUD AND ABUSE AUTHORITIES UNDER THE SOCIAL SECURITY ACT TO ALL PAYERS

In an attempt to diminish distinctions between public and private payers and create a more unified enforcement scheme, the plan creates a series of fraud and abuse enforcement programs that are applicable to all health care providers and all payers. The critical language (applied throughout the proposal) is that various enforcement provisions relate to "any applicable health plan." *See, e.g.*, Sec. 5411(a).¹⁵

For example, Section 5411 of the proposal allows the HHS Secretary to exclude an individual or entity from participation in any applicable health plan for certain Social Security Act violations. For criminal convictions relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care item or service or relating to the neglect or abuse of patients, the exclusion is mandatory for at least five years. Sec. 5411(a). For a variety of other program-related offenses, there is a permissive exclusion from participation in health care programs.¹⁶

The plan provides an explanation of the procedural safeguards for those that may be excluded, the time periods for such exclusions and the provision of notice to relevant health care payers. Sec. 5411(c). The HHS Secretary is obligated to exercise this authority so that a violation results in a person's exclusion "from all applicable health plans for the delivery of or payment for health care items or services." Sec. 5411(d)(1). The Secretary is required to notify each sponsor of an applicable health plan of these exclusions and also to notify the state licensing authorities. Sec. 5411(d), (e). Aside from initiatives of the HHS Secretary, sponsors of applicable health plans, including the states for regional alliance health plans and the Secretary of Labor for corporate alliance health plans, may request the exclusion of particular providers. Sec. 5411(i).

The plan also expands the categories of practices for which the HHS Secretary may enforce civil monetary penalties. Sec. 5412. As with the exclusion authority, these provisions affect actions taken with respect to an applicable health plan. Most generally, this includes civil penalties relating to a number of violations of the Social Security Act. It also creates some new actions that may result in civil monetary penalties, including (1) terminating an individual's enrollment in violation of the plan; (2) discriminating against applicants on the basis of medical condition; (3) inducing enrollment in a health care plan through false pretenses; and (4) providing

¹⁴ The Asset Forfeiture Office of the Department of Justice has been drafting regulations concerning the distribution of forfeited assets. The current regulations are well-suited to situations in which homes or cars are seized, but make little sense in the context of money that has been defrauded. Similarly, the current regulations are not effective in large scale fraud schemes with multiple victims. One of the purposes of these new regulations would be to prioritize the competing interests where there are multiple claims on particular assets, including money. These draft regulations largely were completed at the close of the Bush Administration, but have been pulled back by the Clinton Administration and currently are under review. There is no specific timetable for their release.

¹⁵ The Michel and Chafee plans similarly extend these sanctions to all health benefit plans. The Wellstone proposal, the single payer plan, expands sanctions to the state plans that would be created. It also creates a national health care fraud database and mandates requirements for state anti-fraud units.

¹⁶ These permissive exclusions involve (1) fraud convictions in relation to non-health related government programs; (2) revocation, suspension or loss of a health care license related to professional competence, performance or financial integrity; (3) exclusion from certain government health care programs; (4) performance of medical services that fall to meet professionally recognized standards in a gross and flagrant manner or in a substantial number of cases and other items including failure to repay student loans and failure to provide access to information. *See* Section 5411(b).

financial incentives to enroll in an applicable health plan. Sec. 5412(a). A person may be excluded from the program in addition to receiving a civil monetary penalty. Sec. 5412(b)(2-3). If the federal government does not enforce these penalties against a provider or other person, the state in which the alliance is located may initiate proceedings to impose civil monetary penalties. Sec. 5412(c)(3).

Any money recovered under the civil monetary penalties provision will be paid to the HHS Secretary. Sec. 5412(d). Any amounts determined to have been improperly paid from a health plan will be reimbursed to the plan. Sec. 5412(d)(1). All remaining amounts are to be deposited in the Health Care Trust Fund. Sec. 5412(d)(2). Where civil monetary penalties are enforced, the HHS Secretary will notify the appropriate licensing authorities. Sec. 5412(e).

The program also authorizes civil monetary penalties based on violations of the physician self-referral rules, and extends these provisions to all applicable health plans. Sec. 5413. As set forth below, the proposed changes to the self-referral limitations and anti-kickback rules are quite substantial and would result in significant increased opportunities for enforcement activities.

C. AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS OF THE SOCIAL SECURITY ACT

Part 3 of the Fraud and Abuse plan references an earlier section of the Clinton health care bill relating to amendments to the existing anti-fraud provisions of the Social Security Act. Sec. 5421. The primary goal of this section is to expand the anti-kickback provisions to a wider range of activities, to extend the ban on self-referrals and to clarify certain of the safe harbor provisions to immunize various managed care business practices that the overall reform package seeks to encourage.

These statutory provisions are perhaps the most complicated of the anti-fraud proposals. The bulk of this material is taken up with defining the exceptions to the provisions, in an effort to outlaw inefficient or improper financial inducements while still encouraging appropriate managed care techniques. These provisions are quite controversial and already have generated extensive commentary and debate. Because of their complexity and the lack of impact of many of these exceptions on mainstream private sector anti-fraud issues, we provide below only a general description of the anti-fraud approaches in this area.

In relation to the anti-kickback provisions, the proposal authorizes the HHS Secretary to impose civil monetary penalties for kickback violations (a power she does not now have), up to \$50,000 and not more than three times the amount of remuneration offered, solicited or paid. Sec. 4041(a). The plan also increases the accompanying criminal penalties. Sec. 4041(a)(3).¹⁷

Because of other sections of the bill that incorporate these changes to the Social Security Act, the anti-kickback provisions also will apply to all health claims, not just government claims. This will provide a significantly increased ability for private carriers to attack kickbacks related to privately insured services. Exceptions to the kickback provision include payments for items or services furnished to patients paid for on an at risk basis to that provider furnishing the items or service. See Sec. 4041(b). Also included are payments made on an "at risk" basis to a health plan, including capitation, global fees, and perhaps other bundled payment arrangements. *Id.*

There are other amendments to the self-referral limitations. Sec. 4042. Subject to certain exceptions, the plan prohibits payment for any item or service to an entity with which the physician ordering services has a financial relationship and in which the physician does not render that item or service. The exception to the anti-kickback prohibitions for "at risk" payments to plans and networks also applies to self-referral prohibitions. Sec. 4042(c). The current safe harbor exceptions are retained except that (1) the exception for group practices is narrowed to prevent the creation of sham groups; and (2) the exceptions for investments in large entities require that the company hold \$100 million in shareholder equity.

These provisions represent one of the most controversial aspects of the anti-fraud plan. Many of these issues, however, are of only peripheral interest to the anti-fraud area (although they obviously are extremely important to ongoing business developments in the managed care area). There will continue to be extensive debate on the appropriateness and breadth of the exceptions, given the policy goal of encouraging creative efforts to reduce health care costs. Many of these issues are business issues that should not distract from the primary anti-fraud agenda: To expand the anti-

¹⁷ The Chafee plan creates authority for civil monetary penalties for violation of the anti-kickback law, but does not extend this to private health care plans.

kickback and self-referral bans to all claims, and to broaden the reach of these provisions while still encouraging legitimate managed care techniques.

D. AMENDMENTS TO CRIMINAL LAW

As an additional enforcement tool, the Clinton proposal creates a new series of health care—fraud-related criminal offenses.

Crime of health care fraud

The centerpiece of this section is the creation of a new crime of health care fraud. Sec. 5431(a). This crime involves any person who knowingly executes or attempts to execute a scheme or artifice to defraud "any health alliance, health plan, or other person" in connection with the delivery of or payment for health care benefits, or to obtain, by means of false or fraudulent representations, any money or property of a health alliance, health plan or other person in connection with the delivery of or payment for health care benefits or services. *Id.* A conviction under this section involves a fine or a prison term of not more than ten years, or both. A crime involving "serious bodily injury" can result in life imprisonment.

This crime is based on existing statutory provisions relating to mail and wire fraud. The penalties under the health care fraud section are somewhat more extensive. The crime also is targeted to the health care business. It does not require use of the U.S. mails or interstate wire system, and instead involves efforts to defraud health alliances, plans or other persons through whatever means the perpetrator uses. This statute would fill in some existing gaps in the statutory scheme and would be a useful enforcement tool.¹⁸

Forfeiture of assets

In addition to this new criminal statute, the Clinton plan includes a variety of additional criminal provisions. If a federal health care offense (defined earlier) is one that "poses a serious threat to the health of any person or has a significant detrimental impact on the health care system," the court also should order the person to forfeit property used in committing the offense, that constitutes or is derived from proceeds traceable to the offense or that is of a value proportionate to the seriousness of the offense. Sec. 5432. Currently, proceeds of health care fraud can be forfeited primarily where RICO violations are involved. It is not clear whether this provision extends to purely financial frauds, rather than those that affect patient health interests, as the meaning of "significant detrimental impact on the health care system" is not spelled out. Significant monetary losses should be covered, as, otherwise, this loophole would eviscerate the effectiveness of the forfeiture provision. The amounts forfeited under this section are not to be deposited under the general Department of Justice Asset Forfeiture Fund, but instead go to the health care trust fund discussed above. This forfeiture authority would represent a significant step forward in efforts to recover the proceeds of health care fraud. Although the Supreme Court recently imposed some procedural requirements on the government's ability to obtain forfeitures, this threat would be an important new tool.¹⁹

False statements

The plan also creates a separate crime of false statements relating to health care matters. Sec. 5433. This crime involves both false or fraudulent statements and concealing of material facts, and requires a fine and/or imprisonment of up to five years. This applies to any matter involving a health alliance or health plan, and covers knowingly falsifying documents or concealing material facts by any trick. *Id.*

Bribery and graft

The section creates a new crime for bribery and graft in connection with health care. Sec. 5434. This makes illegal any direct or indirect gift, offer or promise of "anything of value" to a health care official or to someone else with the intent to influence the health care official's actions relating to a health alliance or health plan. It also makes it illegal for a health care official to demand, seek, receive or accept anything of value personally or for any other person. The definition of a "health care official" is quite broad; it means (1) any employee, counsel or other agent of any health care alliance or health plan, (2) any employee or agent of an

¹⁸The Cohen amendment passed by the Senate and the Chafee proposal include similar provisions. The Michel proposal creates a crime of health care fraud that is less defined and applies only to "health care providers." The Michel plan also expands the existing mail fraud statute to include private delivery Services, a loophole currently used to evade the U.S. mail requirement of the mail fraud statute.

¹⁹The Cohen amendment and the Chafee proposal include similar forfeiture provisions.

organization that provides services under contract to any health alliance or health plan, (3) any official or employee of a state agency that has regulatory authority over any health alliance or health plan or (4) an employee or agent of a health care sponsor. A sponsor includes anyone who serves as the sponsor of a health alliance or health plan under the Health Security Act and includes any joint board of employers that administer the alliances or plans.

Injunctive relief

The plan also creates the opportunity for injunctive relief for health care offenses under 18 U.S.C. § 1345. Sec. 5435. This provision now applies to false statements made to the government and to bank fraud, but would be expanded to include anyone who is committing or about to commit a federal health care offense. This section allows the Attorney General to bring suit to enjoin these ongoing violations. This would be an important tool for stopping ongoing fraud schemes and recovering or freezing assets before they disappear.²⁰ Authority under this section is limited to the government; accordingly, private parties are not authorized to seek injunctive relief (although the government can make these allegations in relation to private claims).

Additional criminal provisions

There are a few less important (but equally far-reaching) provisions. In relation to grand jury investigations of health care violations, if an attorney for the government or other government investigator receives information concerning a health care violation, that person may disclose information to an attorney for the government for use in civil proceedings related to federal health care offenses or in connection with civil health care forfeiture. Sec. 5436. Typically, information obtained from grand juries cannot be disclosed even to the civil side of the U.S. government. Currently, this ability to disclose is limited to bank fraud violations *only*, not other criminal violations, where this kind of disclosure of grand jury information is illegal. This provision, like the injunctive relief section, represents part of the effort to focus prosecutorial attention on the health care area, much as bank fraud was a primary target of law enforcement resources in the 1980s.²¹

These provisions, taken together, demonstrate an intent to criminalize an extensive range of inappropriate business techniques and an effort to target law enforcement tools to the specifics of the health care business. These new provisions would go a long way toward closing loopholes and facilitating the overall health care anti-fraud effort.

E. AMENDMENTS TO CIVIL FALSE CLAIMS ACT

The amendments to the Civil False Claims Act also would significantly expand the reach of the federal anti-fraud enforcement scheme. Where now the False Claims Act requires submission of a claim to the government, the act would be expanded to cover claims submitted to any health plan. The specific statutory provision expands the definition of "claim" to include "any request or demand, whether under contract or otherwise, for money or property which is made or presented to a health plan." Sec. 5441 (amending 31 U.S.C. § 3729).²² With this minor language change, the full range of severe sanctions under this act becomes available for all false claims submitted to a health plan, whether public or private money is involved. This statute allows for a civil penalty of at least \$5,000 *per claim*, plus treble damages suffered by the government or the health plan. This would be a substantial enforcement tool.

Although the Clinton plan says nothing on this point, perhaps the most significant effect of this change is on the *qui tam* provisions of the False Claims Act. The *qui tam* statute, as it currently exists (31 U.S.C. § 3730), provides the authority for a private person to bring a civil action for a violation of the False Claims Act on behalf of the government. Once a suit is brought, the government can intervene and take over management of the litigation, if it desires, or the private individual can take the case forward. The private individual (known as the *qui tam* relator) takes

²⁰ The Cohen amendment and Chafee proposal contain similar injunctive relief provisions.

²¹ There are additional crimes of theft or embezzlement from the assets of a health alliance or health plan, Sec. 5437, and misuse of the health security card or other individual identifier. Sec. 5438.

²² The Cohen amendment expands the False Claims Act to all federally funded programs (an extension that may not be necessary under the existing statute), but does not extend it to cover private health care claims. The Chafee proposal similarly extends the act to all health plans, but limits the definition of this term to "federally funded programs."

a portion of the recovery for his efforts. In one recent case, the relator was paid tens of millions of dollars for his role in the action.

There are several crucial elements to these *qui tam* provisions. First, the *qui tam* provision is the closest thing to a private right of action-for health care fraud violations. *The absence of a carefully-tailored private civil cause of action is the most critical omission in the Clinton proposals*, as, with continued resource problems in the law enforcement arena and the potential competition for limited assets, private carriers need the ability to protect their own interests and those of their policyholders, without relying completely on the government.²³

Moreover, under the proposed *qui tam* provisions, a private payer can bring an action if it knows of fraudulent claims involving a health plan. In this instance, the plaintiff would have less control over the action than in a typical civil case, and would receive only a portion of the recovery (the remainder would go the plan). This party also could bring an action on behalf of the government and, presumably, all other health plans as well. To provide a fictional example, if the XYZ Corporation is defrauding one company, and, it believes, the government and other private parties as well, the company could bring a suit on behalf of all of the victims of that provider, both public and private, and could recover a portion of the losses suffered by all of those entities. In fact, any person who is the "original source" of this kind of information could bring such a suit, even, as in one recent case, a former employee of the defendant.

The substantive standard for violation of the False Claims Act also is quite broad. It requires "knowing" submission of a false claim. However, no specific intent to defraud is required. Instead, this "knowledge" can come from (1) actual knowledge; (2) acts in deliberate ignorance of the truth or falsity of the information; and (3) acts in reckless disregard of the truth or falsity of the information. Coupled with the *qui tam* provisions, these amendments would represent a substantial weapon in the enforcement arsenal. While these amendments would substantially strengthen the anti-fraud arsenal, private sector victims should be given a straightforward private cause of action to redress health law violations.

Privacy issues

Aside from the specific anti-fraud proposals, the plan also includes some amendments to existing privacy laws and regulations. We do not propose to review these topics in detail, as they are quite controversial and relate primarily to issues outside of the fraud arena. Nonetheless, there are some important connections with the anti-fraud program.

The privacy section envisions the creation of a National Health Board that will develop and implement a "health information system" to collect and disseminate specific health care data. This information will be used for a wide variety of purposes, including assessing and improving the quality of care, improving the ability of all parties to the health care field to make choices about health care and managing and containing costs of health care. As part of the information that will be collected, the Board will collect "any other fact that may be necessary to determine whether a health plan or a health care provider has complied with a federal statute pertaining to fraud or misrepresentation in the provision or purchasing of health care or in the submission of a claim for benefits or payments under a health plan." Sec. 5101(e)(11). A wide range of organizations are to be involved in developing this system, including representatives of alliances and health plans. These entities also will be involved in creating an electronic data network and health information system privacy standards.

The operating principle of this system is that disclosure of individually identifiable health information is not allowed *unless* a specific exception to this rule is applicable. One of the exceptions relates to "the disclosure * * * to federal, state, or local law enforcement agencies for the purpose of enforcing [the Health Security Act]." While this exception would be applicable to most disclosures of fraud information, it would be useful to include an immunity provision that would protect private payers when individual information is disclosed to law enforcement. It will be important to ensure that the privacy interests are properly balanced with legitimate anti-fraud efforts. Otherwise, as is often the case now, fraud investigations may be hindered by privacy provisions designed for other purposes.

The Clinton plan includes an aggressive array of anti-fraud proposals. Many of these proposals, including the expansion of civil monetary penalties and exclusion authority to all private claims, would vastly benefit insurer efforts to fight fraud.

²³ The Chafee plan creates a private cause of action for competitors injured by kickback violations. The private party must provide notice to the HHS Secretary before filing suit. HHS would then have an opportunity to initiate an investigation.

Other provisions, including mandatory disclosure of private investigative information, would create significant additional burdens for insurers and create the possibility of increased liability exposure. There are some significant omissions to the plan (primarily the absence of a private cause of action) and other areas where there is likely to be expanded competition between private payers and law enforcement over limited financial recoveries. Because of the complexity of these proposals and the interrelationships with the overall health care reform package, it will be important for private payers to monitor the progress of the fraud plan to ensure that the admirable goals of this plan can be met and that the fraud and abuse portions of the plan effectively serve both the private sector and the public interest.

The CHAIRMAN. Thank you. I find myself disagreeing in part with all of you, which means that maybe I am on the right track. I think the AMA has a point. Doctors are in a position where it is so darn easy to be victimized—they may victimized themselves some, but they can become victims very easily.

When you are a professional woman or man, you trade a little beyond your reputation, and it seems to me that the seeking of immunity from the transfer of investigatory information is something that—just so you know, I admit the side of the ledger I come at this from—it is something that I don't want to see you have.

It is one thing if you convict a doctor; it is one thing if a doctor is convicted. The President's bill does not have any sharing of that information, but as I understand it, your organization has a proposal to create a data base which would include information about providers who have been sued and/or convicted of fraud. That kind of data base, it is argued, would help, since there is really no way of checking on a provider now. So you think that is a good idea. Am I getting this correctly?

Mr. MAHON. If I may clarify it a little bit, Mr. Chairman, many of the health care fraud bills that have been proposed in the last couple of years call for the establishment of a national data base of final adverse actions against health care practitioners.

The CHAIRMAN. What does that mean? Translate "final adverse actions."

Mr. MAHON. Convictions, civil settlements, civil judgments against providers who have been found guilty of fraud.

The CHAIRMAN. Now, there are two different things. Settlements aren't "found guilty of." Let's be precise here.

Mr. MAHON. Civil judgments, I should say.

The CHAIRMAN. Civil judgments, OK.

Mr. MAHON. Civil judgments and criminal convictions.

The Health Security Act's fraud and abuse title calls for the Attorney General and the Secretary of Health and Human Services to provide for the sharing of data not only among law enforcement agencies, but from the private sector.

The CHAIRMAN. To the private sector.

Mr. MAHON. No; from the private sector, as I understand it. It is not specific in my reading of it in terms of exactly what it means.

The CHAIRMAN. Well, look, one of the things that I worry about is this, and I would like Mr. Johnson of the AMA to respond to this and I would like you as a practitioner, as well, to respond to it.

I can envision where a doctor—and maybe it is because I was in private practice as a lawyer—I can understand where a doctor, in effect, sued by either an insurance company and/or an action brought by a prosecutor, State or local, civil or criminal, concludes that his or her reputation is gone if they litigate this, if they do

not enter into, say, a settlement in civil court where they do not profess guilt, but, in order to end the matter, agree to a settlement.

I know from my own experience not personally, but as a practitioner, that if you came to me as a—I was your counsel and you were a prominent physician in the community and you said to me, look, here is the deal, I may have made a mistake on such-and-such, there is a bookkeeping error or whatever, but I did not commit fraud, but I have been given an opportunity to enter into a civil settlement where I give relief without having to acknowledge any guilt. What do you recommend, lawyer, that I do for my career and my practice? Do you recommend I litigate this, fight it, or settle it?

Now, I can picture, as a trial lawyer, saying to a doctor that although I think there is a 90-percent chance you will win this, you will prevail, the end result is no one is going to read and the press—and I am not criticizing the press in this, but the press will have one story where you have been found not guilty and/or you have been found not liable, but there will be 4 weeks of headlines about what you allegedly have done. I recommend you settle. I imagine there could be a case where you would tell that to a doctor.

Mr. MATTESSICH. That is correct.

The CHAIRMAN. It seems to me the doctor should not be held accountable for that and it should not be, in effect, information, in this case where he is even just sued, that is made available without you running the risk of the doctor being able to sue you.

Mr. MAHON. Mr. Chairman, if someone is sued civilly or is criminally prosecuted, that becomes public record information by virtue of it, and presumably no one is held liable for exchanging information that is public record.

What we are focusing on is the fact that in case after case we see how true it is that a provider generally is victimizing more than one payer simultaneously in order to make the scheme work. In that instance, it is essential for those payers to be able to exchange information on their active investigations so that companies are not given reason to black-list a provider, as I say, but they are given a heads-up as to the potential need to investigate their dealings with a given provider. At this point, none of this is public record information.

The problem we would like to see addressed is the fact that in many cases, in a smaller insurance company or one that is not active from an antifraud standpoint, company counsel presented with an apparent \$50,000 fraud against the company might first react by saying, well, who is going to sue us and for how much if we make an issue out of this, if we report it to law enforcement or if we file a civil suit against this person.

In the reality of trying to identify the frauds, to establish their true scope, the number of payers they involve, and in order to prove the cases, it is critical to facilitate the exchange of information among the people who are investigating the schemes. State laws acknowledge in many cases the reality of that need and they immunize insurers in varying degrees for the exchange of that kind of information.

The bottom-line point, too, is in many of these cases whether you ever are able to effect a criminal prosecution or obtain a civil recovery in a case or obtain restitution, in many cases if all you do is

stop the bleeding in a given fraud case by being given reason to investigate and establish the basis on which you will deny fraudulent claims, you have accomplished a great deal. When you look at Senator Cohen saying we are losing \$275 million a day, many of these cases will never be prosecuted, but through this information-sharing they will be identified and the bleeding will be stopped.

The CHAIRMAN. I acknowledge that this has been an area of legitimate criticism of me my entire career, but I have this silly notion that unless you are proven guilty by a preponderance of the evidence in a civil court, or beyond a reasonable doubt in a criminal court, you should be able to respond and you should not have immunity.

Mr. JOHNSON. Mr. Chairman, I can't add anything to what you have said. I think you have described the problem accurately. I can understand how the insurance industry wants as much help as it can get from the Government or anybody else in doing this. I would be there asking for all the weapons I could find. Who cares about the consequences?

But the fact is that situation you described happens all the time. It is not uncommon. I have a case right now before our council where we are thinking of kicking out a doctor, and he came in and told exactly the story. He is from Erie County, PA. He is a rural doctor. He is a general practitioner.

Medicaid showed up. He treats Medicaid patients. They went through 50 files; they found 2 where they had problems. They said, you have got 500 cases, we are going to multiply this by 10; that is 20 cases [sic], we believe. That is \$10,000 a case; that is \$200,000.

He calls his lawyer and his lawyer doesn't understand Medicaid or fraud and abuse. Look, can we make a deal here? And they made a deal. He pleaded no lo to this thing. He paid a certain fine.

The CHAIRMAN. No lo contendere, for the record.

Mr. JOHNSON. Yes. So now he comes up and we have to decide whether we want him in here because he has shown up as a violator. He tells us a story that is very compelling. All he has is his reputation and he is facing exclusion from Medicare and Medicaid, and so they made a deal.

I think that if we are talking about real, honest-to-goodness fraud, or schemes that are costing millions of dollars and a lot of patients are suffering or insurers are suffering, we need all the weapons we can get. But in terms of the mundane, run-of-the-mill billing and coding concerns, to expand the kind of reporting and the kind of really, I think, extraordinary kind of exposure that good doctors are going to be faced with, as well as the bad ones, is a mistake.

The CHAIRMAN. Now, I am in disagreement with you. You have just crossed the threshold. This billing, coding, run-of-the-mill stuff adds up to billions of dollars. My problem is your reference constantly to if it is real fraud. You are a lawyer. There is a standard for establishing fraud.

Mr. JOHNSON. Right.

The CHAIRMAN. It is the same standard whether it is real or not real.

Mr. JOHNSON. That is right. We like that standard.

The CHAIRMAN. Right, and that is the standard that, as I understand it, this legislation is required to meet when you are talking about fraud. So I don't have a problem with putting the run-of-the-mill case, the coding violation—that doctor in jeopardy. I don't have any problem with that.

I have a problem with putting a doctor in jeopardy, his or her reputation, when it has not been proven that they have engaged in fraud, or they enter a plea of *no lo contendere* and it is not stipulated ahead of time that part of that plea is they no longer participate.

Mr. JOHNSON. I agree with the distinction. The run-of-the-mill coding problem I refer to as a coding dispute where, given all the possibilities, given all the options, someone has an arguable good-faith claim that we thought we did it the way we should have done it.

The CHAIRMAN. Well, that is the case, though, in almost every endeavor where there is a criminal violation. That is the case in rape. In the case of rape, the issue is one person's word against another, and it is a case where someone says consent and the other says violation. In the case of embezzlement, it is the same thing. In other words, the standard of proof is the same.

Mr. JOHNSON. All the more reason to wait for a conviction.

The CHAIRMAN. I agree with the part about waiting for the conviction. I don't agree with the part about not extending the coverage, if you will, and the civil remedies available with the Government and system-wide. Where I disagree with you is on this issue of whether or not immunity is an appropriate tool. I disagree with that, but my job here is supposedly to listen and not make up my mind. I am acknowledging my prejudice relative to the requirement of proof here and my reluctance to support immunity.

Mr. MAHON. Mr. Chairman, may I make one more clarifying point on that, if I may?

The CHAIRMAN. Yes.

Mr. MAHON. First, no one is suggesting that insurers be given blanket immunity for sharing information on doctors or other providers whom they suspect on very thin grounds of fraud.

The CHAIRMAN. What is thin grounds? You see, all grounds, to me, are thin until it is proven.

Mr. MAHON. What we are suggesting and what State law requires insurers to do in many cases is this. Some State laws require insurers to report suspected fraud to an insurance fraud bureau or to the Attorney General, and so on, and that trend is increasing. Virtually all parties to this discussion have recognized the need for insurers to share information in order to prove a case in the first place, or to prove the true nature of a scheme.

However, in some States you are immune from liability as long as you report your suspected fraud to the State insurance fraud bureau, but not if you report it to the FBI, or not if you report it to an insurance company that is concerned in the case.

The CHAIRMAN. That is because the States made that decision and we have not.

Mr. MAHON. Right. What we are suggesting, however, is that given the multi-State nature of the problem that insurers be given some reasonable degree of immunity for exchanging information

only in good faith. That is a key stipulation, and if they act with malice or an absence of good faith, then the weight of the law should fall on them. But in a practical sense, that is the only way that many of these cases are proven in the first place.

The CHAIRMAN. Well, you know, I support national medical health care; I supported universal. I am angry about the fraud that exists with regard to doctors. I think there should be civil remedies, but, boy, oh, boy, if I am a doctor I am going to begin to worry about a lot of this stuff. It seems to me that this notion of providing immunity—look, the balance is going to shift here, and I am not suggesting it shouldn't, but providers, particularly individual practitioners, are going to be put in a very different position whether or not this legislation passes, just through the whole managed health care system.

They are going to be in a position where, if you have one, two or three outfits in the State, they can be put out of business.

Mr. MAHON. That is right.

The CHAIRMAN. They are going to be put in a position where this equation is changing. My criticism of the AMA in the past has been the same as it has been of the ABA, my outfit, and that is you all haven't come forward with suggested solutions until you let people who don't know as much about it get into the game because you have been irresponsible in not coming forward, in my humble opinion.

But this whole equation is changing, and I think we have to measure the exposure that doctors have to liability and their reputations against the change in the equation and what they are susceptible to with this changed environment. I don't want to turn this into a discourse in the philosophy of the criminal justice system, but I just want you to know, in candor, I am concerned about innocent physicians being caught in a web.

There is a requirement of scienter to prove fraud, and on the civil side it is a preponderance of the evidence. I don't propose to change either of those. I think we should expand it, but I don't think we should be unaware that the burden should fall on those who are moving in the direction of suggesting that someone has, in fact, engaged in an illegal activity.

But, anyway, you wanted to say something, Mr. Johnson?

Mr. JOHNSON. On the civil remedies and who is doing the enforcing and how that goes, we are going to ultimately in this country end up with some large systems in most communities and these systems are probably going to be—a lot of them will be capitulated. They will certainly be very competitive with regard to costs.

It is just hard for me to believe that we need the HHS guys running out throughout the private sector helping Cigna and Aetna and others do these issues with regard to the mundane, the routine, the things that end up being civil sanctions, the penalties. First of all, they will never have the resources to do it. Frankly, they have not done it particularly well. They have a record, but it is not a particularly good record with regard to finding the right cases because it is very hard to do.

Finally, I just don't think that in terms of how we are using our resources and who uses them that it is the wisest way to do it, when you have these businessmen competing for profit,

incentivizing doctors to underutilize care, to add to basically their enforcement budget and their maintenance and administrative budget a huge staff from HHS who runs out. What are they going to do? Are they going to be able to deny a doctor participation in a private plan? Is that the HHS authority?

It just seems odd, particularly as Medicare and Medicaid need their work and continue to require resources and oversight. That is our issue. It has to do with who and how and the focus of the resources. Again, we believe there should be a Federal crime to defraud any health care plan, public or private. We want the FBI to lead it. We are willing to work on it.

Mr. MATTESSICH. Just to speak briefly on that, because the problem becomes—and you hit the nail on the head before with scienter. For instance, in the National Health Labs case which was settled last year where you have got millions and millions and millions of forms and the check is on this block instead of that block, how do you prove that it wasn't simply the fact that the paper didn't fit into the form right, or everybody thought you x'ed this instead of x'ing that?

That is where the HHS auditors—I will put in a plug for them—and the private insurance auditors—they are the ones who know that stuff. The only other ones who really, truly know that stuff are the ones who perpetrate the fraud, and that is where the real crux of the problem is.

The CHAIRMAN. Well, I have trespassed on your time a lot already. I have a couple more questions, but, with your permission, I will submit them to you so you can, if you wouldn't mind, in a timely fashion, return the answers in writing.

The CHAIRMAN. I appreciate your participation. We are a long way from home on this, but I appreciate your input and just hope we make the proper public policy judgment here as we go through this. Thanks a million. We are adjourned.

[Whereupon, at 5:42 p.m., the committee was adjourned.]

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